LEGISLATION TO COVER PRESCRIPTION DRUGS UNDER MEDICARE

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

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LEGISLATION TO COVER PRESCRIPTION DRUGS UNDER MEDICARE

TUESDAY, JUNE 13, 2000

COMMITTEE ON WAYS AND MEANS,
HOUSE OF REPRESENTATIVES,
WASHINGTON, DC.

The Committee met, pursuant to call, at 10:08 a.m. in room 1100, Longworth House Office Building, Hon. Bill Archer (Chairman of the Committee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
June 6, 2000
No. FC–22

CONTACT: (202) 225–1721

Archer Announces Hearing on Legislation to Cover Prescription Drugs Under Medicare

Congressman Bill Archer (R–TX), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on legislation to cover prescription drugs under Medicare. **The hearing will take place on Tuesday, June 13, 2000, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include Members of Congress, as well as other parties pertinent to the development of legislative proposals . However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Although Medicare currently offers a range of health care benefits, it differs significantly from other Federal health care programs and private sector health insurance in that it does not generally offer its enrollees coverage for outpatient prescription drugs. This is significant given that, on average, seniors currently spend in excess of $600 annually on prescription drugs. However, in the absence of Medicare prescription drug coverage, beneficiaries have come to rely upon several other sources of prescription drug benefits, such as employer-sponsored retiree health insurance, Medicaid or other State-sponsored health programs, and managed care plans offered through the Medicare+Choice program. In total, recent data indicates that approximately two-thirds of beneficiaries have coverage through these alternate sources, thus leaving more than 10 million beneficiaries without coverage.

Last year, the Clinton Administration introduced a proposal in his budget to provide a prescription drug benefit for Medicare beneficiaries. The proposal would require seniors to pay a monthly premium to receive the benefit, where the beneficiary would split prescription drug costs with the Federal Government up to a certain amount. The proposal did not address prescription drug costs higher than the benefit cap.

Earlier this year, the concurrent resolution in the budget set aside $40 billion over the next five years to address Medicare prescription drug coverage. House Republicans have unveiled their blueprint to expand prescription drug access through the creation of a public-private partnership that subsidizes all Medicare beneficiaries, provides more choices for beneficiaries to get coverage, and protects beneficiaries from the full amount of extraordinary catastrophic drug costs. Congressional Democrats and President Clinton have announced principles that largely mirror the Administration's earlier prescription drug proposal, which was the subject of a Subcommittee on Health hearing in May (see Health press release, HL–14, dated May 4, 2000). In addition, the Administration's proposal was modified by including a catastrophic drug benefit after beneficiary drug costs surpasses a certain amount.

In announcing the hearing, Chairman Archer stated: "We are committed to strengthening Medicare and adding a prescription drug benefit under Medicare this

year. This hearing will give the Committee an opportunity to explore in greater detail the various plans being discussed, especially the House Republican plan. I look forward to working in a bipartisan fashion toward passing a bill in the House of Representatives that can be signed into law by the President—America's seniors and the disabled deserve action on this critical item this year."

Health Subcommittee Chairman Thomas stated: "We have crafted a plan to lower drug prices for seniors who currently have no coverage by helping them purchase insurance under Medicare. I am pleased that the President has offered a plan that rejects price controls and that Congressional Democrats have offered a plan that rejects price controls and includes immediate protections from catastrophic drug costs. We stand ready to work with Members on both sides of the aisle and in both Houses of Congress to make a prescription drug benefit under Medicare a reality, and this hearing will move us one step closer toward moving legislation that will do that this year."

FOCUS OF THE HEARING:

The hearing will examine legislation proposed in recent months to improve access to prescription drug coverage for Medicare beneficiaries and the related effects on the financial outlook of the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label,* by the *close of business,* Wednesday, June 14, 2000, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Committee office, room 1102 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced andquoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "http: waysandmeans.house.gov".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman ARCHER. The Chair asks members, guests, staff—take your seats, please. We will likely have a rather long day of hearings. Let's try to get started with the least amount of ambient noise.

Today the Ways and Means Committee considers an extremely important subject to all Americans, but particularly those who have reached their senior years. Health problems are exceedingly important to seniors. They are to all of us, but when we are younger I guess we think we are invulnerable and then we get older and we find that we are not.

I know that first-hand because at this moment my 96-year-old mother is in the hospital, and is hopefully getting first-class care. While our seniors are in the hospital, of course, they get coverage for prescription drugs under Medicare. But if they are outpatients where we have hopefully the opportunity to reduce the incidence of needed hospital care, then of course there is no coverage for prescription drugs. On a bipartisan basis, the Congress and the White House desired to find a way to have Medicare coverage on prescription drugs, although there may be differences in approaches.

We have already had full hearings on the administration's proposal for prescription drugs. So hopefully we will not need to further explore that today. But we will be exploring other approaches that are being pushed by Members of Congress and by others who have given thought to this problem. It is important that we find a solution that is ultimately one that will let seniors, on an outpatient basis, have access to prescription drugs on an affordable basis.

Less than 3 years ago, the health care program for our Nation's elderly and disabled was headed toward financial ruin by 2001. Next year, it was scheduled to demise. Yet in the face of severe opposition, we succeeded in saving Medicare for a generation and pushing Medicare's bankruptcy back an additional 24 years to the year 2025. I think all of us can take great comfort in knowing we have done that. But with that extra time comes the added responsibility of modernizing and strengthening Medicare for this and future generations.

Our seniors deserve more than partisan politics on an issue as important to them as prescription drugs. And I hope that we can find a bipartisan answer for this very important problem. The plan that will be presented by Mr. Thomas, on which a great deal of work has been done on a bipartisan basis with Democrat Members of the House, would over the next 5 years give Medicare's 40 million recipients real bargaining power to lower their prescription drug process and will invest up to $40 billion.

Unfortunately, there are defects in every plan. There are certainly defects in the President's plan because the benefits would

tend to vanish over time as drug costs out-pace inflation. So I hope we will look as objectively as possible at all the various approaches and in the end come out with the one which is the most affordable, the most available, and also the one that is affordable to society as a whole in the way that the costs of Medicare will increase.

[The opening statement of Chairman Archer follows:]

Statement of Hon. Bill Archer, a Representative in Congress from the State of Texas

Good morning. Today, the Ways and Means Committee will examine one of the most important health care issues facing seniors not only today, but the 77 million baby boomers who will soon retire and be eligible for Medicare in the coming decades.

Less than three years ago, the health care program for our nation's elderly and disabled was headed toward financial ruin by 2001. Yet in the face of severe opposition, we succeeded in saving Medicare for a generation—pushing back Medicare's imminent bankruptcy an additional 24 years to 2025.

But with that extra time comes the added responsibility of modernizing and strengthening Medicare for this and future generations this year. Our nation's elderly and disabled have waited long enough for Medicare to catch up with the miracles that modern medicine provides today through prescription drugs.

Our seniors deserve more than partisan politics on an issue as important to them as prescription drugs. That's why House Republicans and some Democrats have come together in a bipartisan spirit to craft a plan to lower drug prices for seniors and the disabled who currently have no drug coverage by helping them purchase insurance through Medicare. Our plan invests $40 billion over the next five years to give Medicare's 40 million recipients real bargaining power to lower their prescription drug prices.

Further, benefits under the President's plan vanish over time as drug costs outpace inflation. The non-partisan Congressional Budget Office recently said that, "Assuming that the cost of prescription drugs continues to rise more rapidly than the CPI, **the real value of the [President's] benefit cap would shrink, thereby eroding the benefit**." But perhaps more importantly, our plan will not endanger existing drug coverage that seniors might already have through a former employer, which is a great concern I have with the Administration's plan.

But despite these differences, working together, we can pass a bill and get it signed into law this year. Americans want us to work together to protect Medicare and modernize the program with prescription drug coverage, and that's exactly what we intend to do. We *can* help seniors and the disabled with the costs of prescription drugs. If we put progress before politics and ideas before ambition, we can and will be successful in ensuring Medicare for generations to come. Our seniors and elderly expect and deserve no less.

So having said that, I have now recognized Mr. Rangel for any statement he might like to make.

Mr. RANGEL. Thank you, Mr. Chairman.

I appreciate your thoughts in this being a bipartisan effort. You wouldn't believe that at the Democrat's caucus yesterday there were rumors that we were going to have a hearing today on no bill, that we would have no witnesses, and that we were going to mark up the bill on Thursday. Thank God those rumors are not true and we had to withdraw our request to have a day's hearing for ourselves.

I do hope we can break the tradition of this Committee of not reporting on any bill unless we are guaranteed a veto.

Clearly, the only way we can have a bipartisan bill is for us to talk with each other. I understand my dear friend and chairman of the Health Subcommittee held a press conference this morning in connection with what will be discussed. Some of us did not make

the press conference, but we hope to find out what it is that we hope we can get bipartisan support on.

Clearly, the American people believe that in a time of prosperity and longer life they are entitled to have affordable drugs. Certainly, we don't want a bill that is just helping the pharmaceutical companies and the HMOs. We want something that older people can depend on.

Pete Stark has worked very hard on this subject matter with Democrats on the Committee. I am depending on him and Mr. Thomas to work together and bring something to the Full Committee that we can, with a deep-seated pride, report on.

I would like to yield to Mr. Stark.

Mr. STARK. Thank you, Mr. Rangel.

Mr. Chairman, I just wanted to join in a commitment to provide a drug benefit to the two-thirds of the seniors in this country who lack adequate, reliable, affordable pharmaceutical coverage. About 12 million have no coverage at all. And perhaps another 12 to 15 million have coverage that is in danger of being canceled, reduced, or the premium increased to the point where they can't afford it. We cannot tolerate that.

I think that on behalf of all the Democrats—and I think most of the Republicans—we should have a plan that is absolutely voluntary and that promotes people keeping their current coverage, if they like it, that has catastrophic protection, that is simple, and is run by private contractors not bureaucrats, and uses the private market to negotiate prices and not government price control.

There is one difference, I think, and that is the one-size-fits-all—which doesn't trouble this Democrat. It defines Medicare, perhaps the most popular government program in the country. So that if we have a drug benefit for seniors, it should be for every senior, without regard to where they live, because the rural beneficiaries would be denied coverage in most rural areas under many plans I have heard described. We would strengthen Medicare by providing drug coverage to all seniors, both those in HMOs and those in fee-for-service. And if that is one-size-fits-all, let's stand up and proudly support that particular uniform coverage which we all want.

I look forward to learning and seeing a Republican bill—if there is one—and being able to examine the details and see how it will work to meet those standards.

Thank you for having this hearing this morning.

[The opening statement of Mr. Rangel follows:]

Statement of Hon. Charles B. Rangel, a Representative in Congress from the State of New York

Mr. Chairman:

I am pleased that we are holding this hearing, and that we soon will be marking up a bill at long last to provide help to our Nation's seniors and disabled with the terrible burden of pharmaceutical costs. I appreciate, Chairman Archer, your accommodating a number of our requests for witnesses at this important hearing.

Democrats have proposed a number of bills in this area, and have filed a discharge petition to get full House consideration of either a bill that I, Mr. Stark, Senator Kennedy, and many others have sponsored, or a bill by Rep. Tom Allen that ensures seniors the same discount on drug prices that other large purchasers get.

Two-thirds of our Nation's seniors either have no prescription drug insurance or have inadequate and unreliable insurance. One-third of American seniors have no insurance coverage and they face the highest retail drug prices in the world. It just defies common sense that in this country, where we encourage pharmaceutical man-

ufacturing and where the best drugs in the world are developed, that our seniors pay far more for their drugs than their peers in Canada, France, Japan, or any other nation. That's just not fair to our seniors and, as a result, they desperately need help.

In this time of economic boom, it is unworthy of a great Nation to have millions of seniors rationing their prescriptions—cutting pills in half—to stretch their budgets. A good Medicare drug benefit is the single most important thing we can do to improve the health of our retirees and disabled. Acting now will save lives. It is immoral to do nothing.

Yet, this Committee and this Congress have found the time to pass numerous tax cuts—and will be pursuing more this summer. These tax cuts explode in cost in the out-years, benefitting the very wealthiest in our society. If the Congress chose to hold back on those tax cuts, we easily could afford a prescription drug benefit far, far better than the one on which we will be voting.

The early press reports on the Republican bill indicate it is a give-away to the drug manufacturers and to the HMOs which have been fighting the patient protection bill of rights.

Mr. Chairman, I hope these reports are wrong, and that we can work together to pass a bill that our Nation's seniors need and which helps our retirees with the crushing burden of prescription drug costs. I look forward to working with you in the days ahead.

Chairman ARCHER. Without objection, all members may insert written statements in the record at this point.

[The opening statements of Mr. Coyne, Ms. Dunn, Mr. Ramstad, and Mr. Foley follow:]

Statement of Hon. William J. Coyne, a Representative in Congress from the State of Pennsylvania

Mr. Chairman, I am pleased that the Committee is holding hearings on the need for a Medicare prescription drug benefit. And I am pleased that the majority has finally shown some interest in providing America's seniors with such a benefit. But I am afraid that the legislation that the House Republicans introduced today may not do enough to help the senior citizens in my district who currently can't afford the prescription drugs that they need.

There are a number of concerns that I have about the Republican plan, which was unveiled just this morning.

First, the Republican plan might result in less health care choice for many senior citizens. This proposal purports to guarantee seniors the freedom to choose among plans. It is my understanding, however, that government-subsidized premiums would only cover enrollment in the lowest cost plan available. And that means that many low-income seniors would have to enroll in an HMO in order to get prescription drug coverage—which, of course, would mean that they would no longer be able to consult with any physician they wanted—or in some cases to see their current doctor. The average household income for senior citizens in my district is a little over $13,000. Nearly half of the seniors in my district live on around $9,000 a year. I am afraid that they would have little real choice under the Republican plan. I believe that Congress should preserve the Medicare fee-for-service option as an affordable option for all seniors—and that a Medicare prescription drug benefit should be part of that option.

Second, the proposal appears to do little or nothing to help the seniors with modest incomes—people with household incomes in the $20,000 to $30,000 range. Many of these people, while well-off compared to low-income seniors, are still confronted with hundreds or thousands of dollars in annual prescription drug costs that they often find hard to meet. It seems to me that Congress should enact a Medicare prescription drug benefit that helps all seniors.

In addition, I am concerned about the subsidy that the plan provides to insurance companies. On the one hand, nothing in the bill would require the participating insurance companies to pass the federal subsidies that they would receive along to seniors through lower premiums; consequently, the proposal might prove to be a windfall for insurance companies that does little, really, to help seniors. On the other hand, there is the risk that the program might not work at all. So far, health insurance companies have said that they do not plan to offer prescription-drug only plans even with the subsidies in the Republican plan. If that is, in fact, the case,

the Republican bill would not meet its state goal of reducing prescription drug costs for seniors.

I am a cosponsor of H.R. 1495, the Access to Prescription Medications in Medicare Act. H.R. 1495 would provide all seniors with prescription drug coverage for costs of up to $1700 per year. H.R. 1495 would also cover all costs after the beneficiary pays $3000 in total drug bills in

a given year. I believe that H.R. 1495 would be a better starting point for Medicare prescription drug benefit legislation that the bill drafted by the Committee Republicans.

I would hope that the Committee would spend an adequate amount of time considering the pros and cons of each of these bills. I am concerned that the Committee might vote on the Republican bill this week—only two days after it was introduced. That, in my opinion, is far too precipitous a pace for legislation that will affect millions of seniors on fixed incomes. It seems to me that it would be better for America's seniors that we get it right the first time—rather than having to pass the Medicare Prescription Drug Benefit "Refinement" Act next year.

I look forward to working with my colleagues in a bipartisan fashion to provide a decent, affordable Medicare prescription drug benefit to all of America's seniors.

Statement of Hon. Jennifer Dunn, a Representative in Congress from the State of Washington

Mr. Chairman, I would like to commend you, Chairman Thomas, andother Members of the committee who have worked so hard on this effortto provide prescription drug coverage to Medicare beneficiaries.

We want to give seniors access to an affordable, voluntaryprescription drug benefit. Today, I want to highlight two importantchanges that we can make as part of this comprehensive effort toimprove Medicare for our seniors.

First, we need to ensure access to innovation. Medicare currentlycovers intravenous drugs administered by a health care professional ina hospital or clinical setting, but it does not cover biotechnologyproducts that are self-injected by the patient. As a result, patients with chronic illnesses are being denied access to the latest technology that could help them regain the quality of life they deserve. We must provide access to self-injected biologics not only through a new prescription drug proposal, but also through Medicare Part B. This change makes sound policy, it helps seniors in rural communities, and it helps women who are disproportionately affected by chronic diseases such as rheumatoid arthritis.

Second, we need to rectify payments to Medicare+Choice plans. Reimbursement rates for Medicare+Choice plans are based on the cost of services incurred in a county. However, costs incurred in military facilities are left out of this equation, resulting in lower overall Medicare+Choice reimbursement rates in areas with a significant military presence. To fix this situation, we must count the cost of services provided to military retirees over the age of 65 in military hospitals when calculating the reimbursement rates for Medicare+Choice plans. This is one reason why the reimbursement rates in Washington State are so low, and many health plans have stopped providing service in rural communities. I am concerned that many more health plans will follow in low-payment, urban areas like Western Washington.

I am pleased that the Committee is moving to ensure that Medicare+Choice plans will soon receive adequate funding. In doing so, we will be able to provide greater access in rural communities and low-payment counties. The efforts of Chairmen Archer and Thomas will give the 200,000 seniors in Washington State who participate in Medicare+Choice the opportunity to select a health plan that provides quality care.

I hope to work with the Chairman to address both these problems so that our seniors can continue to receive the care they need.

Statement of Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota

Hearing on Legislation to Cover Prescription Drugs Under Medicare

Mr. Chairman, thank you for calling this important hearing today to review legislation to expand access to prescription drug benefits for seniors.

As founder and co-chair of the House Medical Technology Caucus, I am well aware of the incredible advances that the medical technology industry has made in recent years to treat and cure many illnesses, diseases and conditions. Similar discoveries and innovations have been made in the area of pharmaceuticals.

Sadly, however, Medicare has not kept pace with the incredible strides of American medical ingenuity. I've authored legislation to ensure that seniors have access, through Medicare, to new technologies, and I look forward to similarly working on improving senior access to life-saving and life-enhancing prescription drugs.

I applaud the many proposals—from the Medicare Commission, the President and many of our colleagues in Congress—to address this important issue. Since anything worth doing is worth doing well, we must carefully review all proposals for their strengths and weaknesses, as well as intended and unintended consequences.

At the same time we tackle this important issue, I strongly believe we must also address the issue of access to an affordable Medicare+Choice option under Medicare. These are inter-related issues, as a significant number of seniors currently access some form of prescription drug coverage through Medicare+Choice. And, since seniors in Minnesota, and a number of other efficient or rural areas, have had difficulties attracting and maintaining access to a Medicare+Choice option, we must address the problems that plague this program in certain areas of the country at the same time.

Mr. Chairman, thanks again for holding this hearing. I look forward to learning more from today's witnesses on how we can best address these critical access and coverage issues.

Statement of Hon. Mark Foley, a Representative in Congress from the State of Florida

Thank you, Mr. Chairman, and let me commend you for holding this hearing today to talk about one of the most important issues facing this Congress.

Our seniors face a crisis in health care today. When the Medicare system was begun it was designed as a "sick care" system. That is, when a person over 65 becomes sick, the Medicare program steps in at that point to treat, and hopefully rehabilitate, them. Since that time we have realized the need within the program to take a proactive approach to senior health care by turning it into a "health care" system—instead of treating someone who is already sick, Medicare should put resources into healthy lifestyles and preventive medicine. Because of current advances in medical technology, we know that this type of system can make a difference. A large part of that system, and the developing technology that has led us to it, is pharmaceuticals.

Implementing such a large change to a federal program, as we on this panel know all too well, does not come easily. Our senior population is diverse, as are their medical needs. One of the most important factors in this debate, and one which is often overlooked, is that some 65% of Medicare beneficiaries already have some type of public or private prescription coverage. If these people are in fact happy with their current coverage, they should not be forced into a government system.

In realizing the federal government's role in providing this benefit we cannot underestimate the importance of allowing private providers the opportunity to participate in the plans. At the same time, there must be an incentive for participation. The recent problems within the Medicare + Choice program illustrate this problem perfectly. Congress created a new option for beneficiaries to provide a low-cost Medicare option, but, because of low reimbursement rates, many insurance companies have pulled out of the plan, leaving Seniors with no new option. We must ensure that the prescription drug coverage provided is in fact a viable option.

Cost is another important and troublesome factor in this debate. Ensuring private providers have an incentive to participate is the first step. I have introduced H.R. 4236 which would increase payments to HMOs that participate in Medicare and

provide incentives to HMOs to include prescription drug coverage for their beneficiaries. This is one way to expand the current private drug coverage many seniors enjoy at a lesser cost to the government.

This addresses part of the problem but is not a total solution. I have introduced H.R. 4235 to provide a safety net for low income seniors enrolled in Medicare. We can all agree this is an important component of any new proposal and much of the reason the Medicare program was created in the first place. I commend Chairman Thomas for his hard work in this area and want to impress upon him my willingness to work to see that a comprehensive plan is passed this year.

Finally, to ensure that all seniors have options, we must include in any plan those seniors who may not fall in the "low—income," may not be fortunate enough to have private coverage, or may struggle to pay for their supplemental coverage. To help these people I have proposed H.R. 4234 to provide a tax credit for those who pay for their own drugs or who participate in a supplemental insurance plan. This is a simple step to help ensure all seniors have a viable option to help cover necessary but expensive drug costs. I hope the committee will consider each of these proposals as a part of an overall prescription drug plan.

I feel confident we will hear quite a few viable ideas and proposals today and hope that this discussion will lead us down the path to passing an effective prescription drug plan for seniors this year. Let me simply take this opportunity to implore my colleagues on both sides of the isle to remember the importance of this issue to those it will benefit. Election year politics can often impede the path of such important proposals. Seniors in my district and throughout the country need prescription drug coverage now, not an election year issue. I am deeply concerned over reports that members who have reached across party lines to form a consensus on this bill may face political consequences. I renew my commitment to seeing a bipartisan prescription drug plan passed this year, and hope that I can count on my colleagues to put partisan politics aside and do what is right for our nations' seniors.

Chairman ARCHER. Our first witness this morning is one of our own, the chairman of our Health Subcommittee, Mr. Thomas. He is joined, as I understand it, on a bipartisan basis with the gentleman from Minnesota, Mr. Peterson. I understand the two of them have been working together on a plan.

Mr. Thomas, we are pleased to receive your testimony this morning. How does it feel on the other side?

STATEMENT OF HON. WILLIAM M. THOMAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. THOMAS. Thank you, Mr. Chairman. It is an impressive view from this side of the table.

I am cognizant of a number of members who won't have the number of opportunities I will have to intervene over the next several days, so I have no written statement and I will make a very brief oral statement.

I share in the vision of my colleague from California, Mr. Stark, with just a couple of exceptions. I think one of the concerns that we brought from the President's program wasn't that it was a one-size-fits-all, but that it was a one-size-fits-some. That in fact seniors who are worried about their prescription drug costs are not worried about the first dollar but are worried about the last dollar. So rather than a prepaid plan of one-size-fits-some, what we are trying to move forward on a bipartisan basis is insurance for all seniors.

As my friend and colleague, Mr. Rangel, said, we are going to move forward on a bipartisan basis. If you will recall, on the Balanced Budget Act, Medicare reforms passed this Committee 34 to

1. My goal is always to better ourselves and my goal is to have a unanimous vote.

I tell my friend from New York that at 9:30 we held a bipartisan press conference. The work product that will come that will come out of the bipartisan working sessions that have been going on for more than a year will have the imprint of a number of Democrats, but the number of Democrats who have had input and the number of Democrats who feel comfortable standing up at the beginning of the process is a decidedly different number.

I do believe that when the bill goes to the floor and the final vote is recorded, that will be more than enough evidence that this plan is bipartisan.

I am also pleased to have my colleague from the other side, the Senator from Louisiana, Senator Breaux, because we spent more than a year looking at various proposals in great detail with the best minds available to us, both intensively and extensively examining options. I think all of us are in agreement: This needs to be an addition to Medicare; it needs to be an entitlement; it needs to be voluntary; it needs to be available in every corner of the United States.

One of the things of which we are becoming more and more aware is that there probably needs to be a structural change as well. As the Medicare Program has advanced, one of the things we did in 1997 was add choice to the Medicare Plus Choice Program. But, frankly, the administering of that program has not been what many of us would have thought appropriate. In fact, it is also true to others on this panel because they have examined the Health Care Financing Administration and said perhaps it is time that we look to a different entity to provide the nurturing of the benefits to seniors.

And that is why in this bipartisan proposal we will include the creation of a new administrative entity called the Medicare Benefits Administrator under the health care structure of the Health and Human Services Department. It is not something radical or rogue. It is an entirely appropriate maturing of the administrative structure.

But as we begin to get these details examined, I think you will find to a certain extent there is some commonality. As we did in 1997 with my colleague to my immediate left, it isn't stressing the differences that will get us a bill this year, it will be stressing the commonalities. That is why I was saddened a bit by the White House press conference yesterday—and I assume it will continue—and I hope some of my colleagues will take note of the fact that what we need to do is to take a look at the similarities in the proposal, work on the differences instead of emphasizing the differences because if we emphasize the differences it will be extremely difficult to come to agreement.

I look forward to working with my colleagues to advancing Medicare to making sure that seniors—wherever they are and in whatever plan they have—have an opportunity to examine the new prescription drug program and make a choice. Is this program better than the one they have? Is it a program that now is a program where they don't have one? That choice American seniors deserve.

It is overdue and we ought to do our job and move forward in a bipartisan way.

Thank you very much, Mr. Chairman.

Chairman ARCHER. Thank you, Mr. Thomas.

Chairman ARCHER. Our next witness is also a member of our Committee, a very strong contributing member from the Minority side. Before I recognize you, the Chair would observe we have 10 minutes left on this initial 15-minute vote. I am told there will be another 5-minute vote on the heels of that. The Chair would like to wait as long as we can toward the end of this 10 minutes and then stay over for the two votes and come back immediately for the rest of this panel.

Senators, I am sorry about this, but as you know, there is nothing we can do about it.

I know they will want to stay for questions, too, so it is not just the presentation. Otherwise, I would say go ahead.

Mr. Cardin?

STATEMENT OF HON. BENJAMIN L. CARDIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. Chairman, I agree with Mr. Thomas. I hope that we can work out and enact prescription drug benefits under Medicare this year. Each of us in our districts is hearing from our seniors on a very regular basis—and rightly so. Let me just tell you one example in my district of a person who was at a supermarket and went through the check-out line. She had some groceries and she had three or four prescription drugs. She took out some of her groceries and she took out some of her prescription drugs because she couldn't pay the full bill.

This is a common story in all our districts. I have constituents who have out-of-pocket costs of $1,000, $2,000, or $3,000 a year. They just cannot afford it and they expect that Medicare would cover these costs.

I was listening to Mr. Stark and was listening to Mr. Thomas about one-size-fits-all. That is not Medicare. Medicare has been probably the most successful program we have ever had, certainly in the insurance field, to cover our seniors. It is not one-size-fits-all. You can get your care provided under fee-for-service, under an HMO, your employer may provide benefits for you, you might be using a Medigap plan. But the key thing about Medicare is that we have core benefits of covered service that you know as a senior you will be entitled to get those benefits.

I would hope that the standard that we would be using to judge the plans—I would hope where we would start is that prescription drugs should be no different than physician services. A senior should be guaranteed that it is a covered service. How the senior receives those services could well be through fee-for-service, through an HMO, or through some private insurance. That is fine. But let us make sure it is in the core plan.

That is one reason why the bill that Senator Kennedy and my friend, Mr. Stark, will be speaking about complies with that requirement. I support that approach.

Let me talk about a bill I filed last year, H.R. 1796, the Medicare Chronic Disease Prescription Drug Benefit Act. I was joined by Congressmen Coyne, Levin, Stark, and Thurman. That bill recognized the fact that we need to include prescription drugs in the core benefits of Medicare. However, that we could not do it all at one time, that it would be too expensive.

But what we did there was to pick certain diseases that we knew would provide preventive health care for our seniors. If they take their prescription drugs, they will stay out of the hospital and stay healthier. We also know that these prescription drugs would be extremely expensive. So this bill has a catastrophic coverage aspect to it. It also includes drugs that people won't take unless they need to take them. You don't take drugs for hypertension unless you need to take those drugs. The diseases were hypertension, major depression, rheumatoid arthritis, heart disease, and diabetes.

And we have a mechanism to add additional diseases that are truly for preventive care. There is cost-containment in our legislation through the use of a deductible, co-payment for brand name drugs and pharmacy benefit managers.

Mr. Chairman, I will put my entire statement in the record and I will be very brief today because I have the privilege of serving on this Committee.

The bill that I filed and the bill that Mr. Stark filed—both expand Medicare's core benefits to include prescription drugs. I think if we start with that one principle, then I think we will have room in which we can reach agreement to be able to bring out prescription drug benefits for our seniors, this year.

I thank the chairman for his time.

[The prepared statement follows:]

Statement of Hon. Benjamin L. Cardin, a Representative in Congress from the State of Maryland

Chairman Archer, Ranking Member Rangel, and fellow Members of the Ways and Means Committee, I appreciate the opportunity to share my views with you on one of the most pressing problems facing America's older and disabled citizens today-access to comprehensive medical care. Medicare, the federal health insurance program for the elderly and disabled, covers a wide range of medical services-inpatient hospitalization, physician services, physical and occupational therapy, skilled nursing facility, home health and hospice care are all covered. Yet, despite Medicare's success in eliminating illness as a major cause of financial ruin for elderly Americans, the burden of high prescription drug costs remains a source of hardship for many beneficiaries.

When Congress created Medicare in 1965, prescription drugs were not a standard feature of most private insurance policies. But health care in the United States has evolved considerably in the last 35 years. Now most private health plans cover drugs because they are an essential component of modern health care. They are viewed as integral in the treatment and prevention of diseases. But Medicare, for all its achievements, has not kept pace with America's health care system. Regardless of our party, we can all agree that it is time to modernize Medicare to meet our beneficiaries' needs.

Because Medicare does not cover prescription drugs, its beneficiaries, 80% of whom take a prescription drug every day, must either rely on Medicaid if they qualify, purchase private supplemental coverage, join a Medicare HMO that offers drug benefits, or pay for them out of their fixed incomes. Without coverage, these costs can be extraordinarily burdensome for the elderly, who already have the highest out-of-pocket costs of any age group and who take, on average, eighteen prescriptions each year.

Medicaid does provide prescription drug coverage. But nearly 60% of Medicare beneficiaries with incomes below the federal poverty level were not enrolled in Medicaid as recently as 1997. And even Medicaid enrollees with drug benefits must

forgo some of their medications. In fact, eleven state Medicaid programs have imposed caps on the number of prescriptions covered each month.

The drug coverage available through Medigap leaves much to be desired. Only three of the ten standardized Medigap plans offer drug coverage, and these plans-H, I, and J—have limits on the benefits and high cost sharing. Two plans have caps of $1250, and the third has a cap of $3000. The high cost of these Medigap policies has put them out of reach for most low- to-moderate income Medicare enrollees. In my home state of Maryland, a 70 year-old beneficiary must pay anywhere from $1100 to $3550 per year for such a plan.

Some beneficiaries get drug benefits through retiree health plans. Although between 60 and 70 percent of large employers offered retiree benefits in the 1980s, fewer than 40 percent do so today. Of these employers, nearly one-third do not include drug benefits in the package.

So that leaves Medicare HMOs, which are rapidly vanishing as an option for seniors. Nearly 1 million seniors are likely to lose their Medicare+Choice plan at the end of this year. In 2001, none of Maryland's rural counties will have a Medicare+Choice option. This is the dismal situation in a state where only three years ago every senior had access to at least two HMOs, and some could choose from as many as eight. But access to drugs in a Medicare HMO is not only a rural problem. Next year, we will have just two plans available to our urban beneficiaries; both will impose a monthly premium, and at best, the drug benefit will be capped at $1000. Last year, Medicare+Choice enrollees from my district, which is centered in Baltimore, told me that they had to rely on pharmaceutical samples to get sufficient amounts of medications because of the caps imposed by their plans.

The problem of HMO withdrawals is often cast as a payment issue. But the HMOs themselves say that other factors play an equal if not greater role in their decision to leave Medicare. Raising the payment floor to $475 or $500 in Maryland would not have prevented insurance companies from leaving Cecil Country, where the 1999 payment was $532, or Allegany County, where the 1999 payment rate was $574. None of the seniors in these counties has any Medicare+Choice option now. Rather than spending money to selectively prop up private plans, Congress should add a drug benefit to the basic Medicare package. This would allow Medicare+Choice plans to compete on the basis of their ability to manage care rather than on how deftly they can move money from column A to column B to finance an ever-shrinking drug benefit.

Our examination of the current landscape has made us painfully aware of the gaping hole in Medicare's safety net. We can repair it now before more elderly and disabled citizens fall through. A comprehensive Medicare drug benefit is expensive, and we are limited in how broad a package we can create immediately.

In the first session of this Congress, joined by four of my colleagues on this committee—Mr. Coyne, Mr. Levin, Mr. Stark and Mrs. Thurman, I introduced legislation that takes an important, incremental step. HR 1796, the Medicare Chronic Disease Prescription Drug Benefit Act, recognizes the importance of preventive care and provides coverage for drugs that have been determined to show progress in treating chronic diseases. Why chronic diseases? Because the average drug expenditures for elderly persons with just one chronic disease are more than twice as high than for those without any. And because we know from years of advanced medical research that treating these conditions will reduce costly inpatient hospitalizations and expensive follow-up care. This legislation has built-in catastrophic care. It provides medications for those beneficiaries with the greatest need for assistance: the GAO study of the Medicare+Choice program has shown us HMOs enrollees are younger and healthier than those in fee-for-service Medicare. This tells us that it is the older, sicker seniors, precisely the ones who need more medications, who have reduced access to drug benefits because they are not in HMOs.

HR 1796 addresses their needs. It begins with five chronic diseases—diabetes, hypertension, congestive heart disease, major depression, and rheumatoid arthritis—that have high prevalence among seniors and whose treatment will show improvement in beneficiaries' quality of life and reduce Medicare's overall expenditures.

The Medicare costs associated with inpatient treatment of these diseases are exorbitant.

• **Hypertension** is a major risk factor for heart disease, stroke and kidney failure, affecting nearly 40% of all Medicare beneficiaries. It is responsible for 32,000 inpatient admissions each year.

• **Major depression** affects more than one million beneficiaries, more than any diagnosis except heart disease. Medicare spends $1.8 billion each year for 320,000 admissions to treat major depression. Treatment has been found to reduce overall health costs by 29%.

• **Rheumatoid arthritis** affects more than 1.75 million beneficiaries. The annual rate of hospitalization (34%) is nearly twice the rate for all Medicare beneficiaries (18.7%).

• **Heart disease**is the largest single cause of death for the elderly. Drug therapy can reduce death rates for heart patients by 40%, but only half the people who could benefit from these drugs receive them. Medicare spends $7 billion annually for inpatient treatment of heart disease.

• **Diabetes** affects six million Americans over age 65. This Committee recognized the importance of preventive care for diabetes in 1997, when we passed the Medicare preventive benefit amendments that for the first time paid for glucose monitors, test strips, and self-management training for diabetics. I will use this disease to further illustrate my point:

• Diabetes is the leading cause of end-stage renal disease. • People with diabetes are twice as likely to have heart disease and to suffer a stroke as people without diabetes. • The risk of leg amputation is up to 40 times greater for diabetes sufferers. • Each year, Medicare pays for 56,000 admissions for amputations, and spends $700 million on inpatient costs. • Amputees are far more likely to require home health care and nursing home care. • Medicare spends an estimated $28.6 billion annually treating diabetics. • With proper treatment with insulin, diabetes can be managed and most of these costs can be avoided.

HR 1796 provides coverage for drugs after an annual $250 deductible is met, with no copayment for generics and a 20% copayment for brand-name drugs. QMBs and SLMBs will be exempt from deductibles and copays. Pharmacy Benefit Managers (PBM) under contract on a regional basis with the Health Care Financing Administration will negotiate with pharmaceutical companies to purchase these drugs and will administer the benefit.

This bill covers five major chronic conditions, but we know that there are others that should be covered as well. Our bill provides a process for the Institute of Medicine to determine the effectiveness of this benefit and the Medicare savings it produces, and to recommend additional diagnoses and medications that should be considered for coverage.

Mr. Chairman, modern medicine has the capability of doing extraordinary things, and the nation's pharmaceutical companies should be recognized for their contributions toward curing disease and improving the quality of life for many. But no medical breakthrough, no matter how remarkable, can benefit patients if they can't get access to it. My bill is a cost-effective, economically sound approach to prescription drug coverage is a matter of common sense: if Medicare beneficiaries can secure the medications they need, they will be able to manage their conditions, and they will be much less likely to require extended and costly inpatient care. This legislation is a first step, and a major step, toward making this a reality.

I also support the comprehensive drug benefit bill introduced by my colleague from California, Mr. Stark. Both of these approaches establish prescription drug coverage as a guaranteed benefit under the Medicare program. Both approaches recognize prescription drugs as an integral component of medical care. Both approaches ensure that seniors' access to drug coverage will no longer depend on where they live. Both approaches mean that our seniors will have coverage for prescription drugs, and they will not be dependent on an insurance company's business decision, which could reduce or eliminate their benefits. And finally, both approaches expand choice. For seniors who want to maintain traditional Medicare, they guarantee the availability of drug coverage. For seniors who choose private health plans, they reimburse these plans for the cost of drugs, thereby encouraging them to stay in the program. For seniors who have retiree health benefits, they support the ability of employers to fulfill the promise of retirement security they have made to their workers.

Congress created Medicare in 1965 to provide health insurance coverage for vulnerable citizens when the private sector would not do so. We enacted a benefit that was guaranteed to all without regard to income or place of residence. We have convened today, because, again, the basic health care needs of our beneficiaries are not being met by the private sector. As we work to modernize Medicare, let us make certain that all enrollees have access to prescription drug coverage regardless of income, regardless of place residence, and always with the health of our beneficiaries as our primary objective.

Chairman ARCHER. Thank you, Mr. Cardin.

Our next witness is a gentleman well known to the Congress and to the Nation and has been most active in health issues over the years. Senator Kennedy, we are pleased to have you here in the Ways and Means Committee and will be pleased to hear your testimony.

STATEMENT OF HON. EDWARD M. KENNEDY, A UNITED STATES SENATOR FROM THE STATE OF MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman. It is a pleasure to be with my colleagues here on this panel, all who have given a great deal of thought and attention to this issue. I commend them and I thank you, Mr. Chairman, for your involvement. I also thank Congressman Thomas who works on this issue and our chairman, Mr. Rangel, and Congressman Stark as well.

If I could, Mr. Chairman, just walk through these charts very quickly. We have high drug prices for seniors. Prescription drug coverage for seniors is going down. One-third of our senior citizens have no drug coverage. Employer-sponsored coverage is going down rapidly every year. Medicare HMO deductibles are going up. The only group of seniors that really has any health care guarantees are those seniors on Medicaid.

Second, Mr. Chairman, you see on this chart, Medicare HMOs are reducing their level of drug coverage. This year, 75 percent will cover less than $1,000 in prescription drug costs and 32 percent will cover $500 or less. The major sources by which our seniors are getting their prescription drugs are in a state of collapse. If you add to that the increased cost of Medigap plans that provide drug coverage, that collapse is evident.

On this chart we see the increase in drug costs. We have the costs of CPI versus the costs of prescription drugs. So we have the collapse of drug coverage at the same time we have an increase in cost.

Next, most seniors do not have high incomes. The meidan income for a senior is less than $14,000. This is very important. People talk about middle-income senior citizens and high-income senior citizens. When you have 78 percent of our seniors with incomes below $25,000, you are talking about a very limited group. That is why universal coverage is so compelling. We are basically talking about people at the margin.

We believe that there should be coverage for all seniors. It should be voluntary. You ought to have basic coverage, which is essential and some level of catastrophic coverage. You have been through the President's bill. I won't take the time to go through it. It does provide coverage for all, it is voluntary, it has a catastrophic provision, and it is affordable.

Now let me just mention, Mr. Chairman, my concern about the Republican proposal. It is inadequate in terms of the government contributions. It leaves out too many seniors and is too costly for middle class seniors.

The impact on Medicare beneficiaries of an inadequate government contribution is that you still leave many seniors with no coverage whatsoever. Under the administration's program, the President's program, the government contribution is 50%, so it will likely cover all 12 million seniors without drug coverage. Under the

Republican proposal, the government contribution is only 25%, and is estimated to result in coverage for 6 million. So we have to ask ourselves, Is this really a program or a promise? Which 6 million seniors are we going to leave out? It seems to me, if we are really going to do the job, we can't afford to leave out half of those who are not going to have the coverage.

Second, contrast the cost. Under the administration's program, when fully phased in premiums will be $575 annually versus $1,276 under the Republican plan. So you are talking about half the number of seniors that will be covered because the cost is more than double.

Now, Mr. Chairman, looking at the blue chart one more time, you are going to have second-class coverage for low and middle income seniors. You are going to guarantee $500, or $700, or whatever it is, but it is going to be the cost for the lowest priced benefit package. When that happens in our health care system, it means an inadequate benefit. We are going to accelerate a two-tier system, I believe.

The Republican plan does not have a defined benefits program, Mr. Chairman. I think it is absolutely essential that in any program that is going to be given its worth you provide a defined benefit. I believe that there is excessive reliance on the private insurance industry. I think this Committee made the wise decision at the time Medicare was enacted to recognize that the private insurance industry is not adequate to deal with the issue.

These are the central concerns. I am concerned that this is a promise without the reality. It is not a real true Medicare benefit. It leaves out too many seniors. It is too costly for the middle class and there is no guarantee of defined benefits.

I thank the Chair.

[The prepared statement follows.]

Statement of Hon. Edward M. Kennedy, a United States Senator from the State of Massachusetts

Thank you, Chairman Thomas and Congressman Stark, for the opportunity to testify on this very important issue. You have both been leaders on this issue, and I welcome the opportunity to share my views with the Committee. No issue is more important to senior citizens than prescription drug coverage under Medicare. There is no issue facing this Congress in which a bipartisan solution is more important.

The need for action is as clear as it is urgent. Medicare is a specific contract between the people and their government. It says, "Work hard, pay into the trust fund during your working years, and you will have health security in your retirement years." But that commitment is being broken today and every day, because Medicare does not cover prescription drugs.

Too many elderly Americans today must choose between food on the table and the medicine they need to stay healthy or to treat their illnesses. Too many seniors take only half the pills their doctor prescribes, or don't even fill needed prescriptions at all—because they can't afford the high cost of prescription drugs. Too many seniors are paying twice as much as they should for the drugs they need, because they are forced to pay full price, while almost everyone with a private insurance policy benefits from negotiated discounts. Too many seniors are ending up hospitalized—at immense cost to Medicare—because they aren't receiving the drugs they need at all, or can't afford to take them correctly. Pharmaceutical products are increasingly the source of miracle cures for dread diseases, but senior citizens are being left out and left behind because Congress fails to act.

Senior citizens are being hit by a one-two punch. Coverage is declining-and costs are soaring. 12 million senior citizens-one third of the total-have no prescription drug coverage at all. Surveys indicate that only half of all senior citizens have prescription drug coverage throughout the year. Coverage through employer retirement plans is falling. Medicare HMOs are cutting back. Medigap plans are priced out of

reach of most seniors. The sad fact is that the only senior citizens who have stable, reliable, affordable drug coverage today are the very poor on Medicaid.

Prescription drug costs are escalating. Since 1996, costs have grown at double-digit rates every year. Last year, the increase was 16%, while the increase in the CPI was only 2.7%. No wonder access to affordable prescription drugs has become a crisis for so many elderly Americans.

It is long past time for Congress to act. There are four basic principles that any prescription drug proposal should meet.

It must cover all senior citizens.

It should be voluntary.

It must provide both basic coverage *and* catastrophic coverage.

It must be affordable for senior citizens.

Coverage for All

Medicare and Social Security are the two most successful federal social programs ever enacted. One of the reasons that they are so popular and effective is that they cover all senior citizens. Everyone-rich and poor alike-contributes during their working years. Everyone benefits during their retirement years. That model must be preserved for a Medicare prescription drug benefit. Additional help can and should be provided for the low income elderly, but the benefit must be one in which government and senior citizens share in the cost at all income levels. Senior citizens want Medicare, not welfare.

As a practical matter, a program targeted on the low income elderly won't meet the need. The vast majority of the elderly are of moderate means. A program restricted to the low income elderly will still leave millions of senior citizens unable to afford the prescription drugs they need. Fifty-seven percent of seniors have incomes below $15,000 a year, and 78% have incomes below $25,000. Only 7% have incomes above $50,000 a year. The older they are, the more likely they are to be in poor health-and the more likely their limited income cannot meet their health needs.

A key component of coverage for all is a fair sharing of costs between the government and the beneficiaries. Only if the government pays a substantial share of the premium-a minimum of 50%-for every beneficiary can affordable coverage for all be guaranteed and the principle of social insurance be maintained.

Voluntary coverage

There is no need for a mandatory program. A program that is voluntary will gain the broadest possible public acceptance. If it is well-designed, it will assure that every senior citizen has adequate, affordable coverage from some source.

Basic and Catastrophic Coverage

It is clear that Medicare should cover both basic prescription drug expenses and catastrophic expenses. The basic coverage will meet the needs of senior citizens with moderate drug costs, and the catastrophic coverage will protect those who need very expensive drugs.

A drug bill of $200 or $100 or even $50 a month is a heavy burden for most senior citizens. They deserve help in meeting these expenses. A program that asks them to pay premiums and receive no basic benefits is not defensible. That is why a basic benefit is essential.

But a basic benefit alone will not help those who need drugs costing thousands of dollars a year. Increasingly, many of the miracle drugs that are coming on the market have price tags at those levels. Often, they save money for the system overall, by reducing the need for costly hospital and physician care. But senior citizens will not be able to afford these medications unless Medicare includes catastrophic protection.

Affordability

Premiums under the new program must be affordable for senior citizens. Special help needs to be provided for the low income elderly, but the government should share in the premium cost for all of the elderly.

Affordability also has another meaning, however. Millions of Americans with private insurance coverage pay much less for prescription drugs today than senior citizens pay. Citizens of foreign countries often pay a small fraction of the American price. Government agencies like the Veterans Administration receive large discounts. Private purchasers who buy in bulk—such as HMO's, insurance companies, and large corporations—all receive substantial discounts.

Any Medicare prescription drug coverage should be set up to provide the benefits of bulk purchasing for senior citizens. Any program we are likely to enact will still leave senior citizens responsible for paying a significant proportion of the costs of the drugs they buy. They deserve to pay that proportion based on a fair price, and taxpayers deserve a fair price, too.

The bill introduced by Senator Daschle, Senator Moynihan, myself, and the majority of the members of the Democratic caucus in the Senate embodies each of those principles. It effectively meets the need of every senior citizen for affordable coverage. It provides basic and catastrophic benefits at a price the elderly can afford—and I hope that, with the new surplus projections expected later this month, we will be able to improve it further. It assures that Medicare beneficiaries will receive drugs at the same discounted prices now available only to the biggest purchasers. And it supports and improves existing coverage through employer retirement plans and Medicare HMOs.

As important as it is to pass Medicare prescription drug coverage that does the right thing for the elderly, it is equally important not to pass a program that pretends to do the job but does not. There are four specific pitfalls that we should avoid.

First, a program that only subsidizes the very low income elderly and provides no government contribution or a very limited contribution to the vast majority of moderate income senior citizens will leave out too many in need and impose excessive premiums. Senior citizens at 150% of the poverty level have an income of only $12,000. If they have to pay the full premium of a plan similar to the President's, the cost would be approximately $1,300 a year, before a dime's worth of coverage was received. CBO has estimated that even with a 25% contribution, half of all the senior citizens who have no prescription drug coverage today would be left out. This result is clearly unacceptable.

Second, the premium contribution should not be based on the cost of the lowest priced plan in an area, if multiple plans are offered. To do so would be an invitation to segregate those of low and moderate income into substandard programs.

Third, the program should provide a defined and specific benefit-not one based on a concept of actuarial equivalence. The elderly deserve to know what they are getting. Insurance companies should not have the opportunity to manipulate benefits to attract the healthy and force the sick into the highest cost plans.

Finally, there should not be excessive reliance on the private insurance market. Private insurance has a proven track record of failure in meeting the needs of the elderly. The cost of selling and administering individual insurance programs is unacceptably high, compared to Medicare. Benefits the elderly need and deserve should not be used to subsidize insurance company profits or excessive administrative costs.

Few if any issues facing this Congress are more important than giving the nation's senior citizens the health security they have been promised. The promise of Medicare will not be fulfilled until Medicare protects senior citizens against the high cost of prescription drugs, in the same way that it protects them against the high cost of hospital and doctor care. I urge this Committee to act, and act promptly, to meet this pressing need.

[Charts are being retained in the committee files.]

Chairman ARCHER. Thank you, Senator.

Senator KENNEDY. I am glad to clear the room. That happens to me all the time over in the Senate, too.

[Laughter.]

Chairman ARCHER. The Chair exhorts members to hurry over and vote, then we will do the second vote and come back. The Committee will stand in recess.

[Recess.]

Chairman ARCHER. We have a lot of witnesses, so the Chair encourages everybody to take their seats and cease ambient noise.

Our next witness is another respected Senator, who has spent long hours toiling the financiers of Medicare and the co-chairman of the Medicare reform commission last year. We are happy to have you before us today, Senator Breaux. We will be pleased to receive your testimony just as soon as the outside noise abates.

STATEMENT OF HON. JOHN BREAUX, A UNITED STATES SENATOR FROM THE STATE OF LOUISIANA

Mr. BREAUX. Thank you very much, Mr. Chairman and Members of the Ways and Means Committee.

I don't know whether it was something Senator Kennedy said that cleared the room or the expectation of what I might say that cleared the room, but we are glad that you are back.

It is really interesting that co-chairman Thomas and I had our last Medicare Commission meeting in this very Ways and Means Committee hearing room. We are glad to be back and hopefully this is not the last meeting of the Ways and Means Committee on this very important issue.

Congratulations to you, Mr. Chairman, and to all the members, first of all for having this detailed hearing on the issue of prescription drugs followed by the very somewhat novel concept of actually scheduling a markup on the legislation, which I think is incredibly important if we are going to get anything done in the few remaining days we have in this Congress.

Thank you for the schedule you have set out. I hope the Senate will be able to follow your leadership and actually move to a markup if we are going to get anything done other than have an issue to talk about. We can all have an issue about whose fault it is that prescription drugs are not passed in this Congress, but then we will be arguing about failure and whose fault it is. If we want to actually get something done for seniors, it is going to take some setting of schedules, scheduling markups, and working toward a bipartisan agreement.

Otherwise, we are not going to get anything done other than create an issue for each party to argue about in the upcoming elections. That would be a real tragedy, and I know that we do not want that to happen.

Let me make basically two points. The first point is that we should use the issue of creating a prescription drug plan for seniors as a means to also at least put a downpayment on Medicare reform. It is actually quite easy just to spend $40 billion on prescription drugs. We could agree on how to do that. It is not that much of a problem. But if we can agree that we are going to have $40 billion for prescription drugs over 5 years, let us at least use that to get some minute degree of reform of the Medicare Program itself in order to package the two together.

I think it would be a serious mistake just to add $40 billion to the existing program without any reform at all. We all know the problems with Medicare. Medicare benefits only cover about 53 percent of the average senior's health costs and 47 percent comes out of their pocket. It is not nearly as good as it should be. The average senior, according to AARP, spends over $2,400 out-of-pocket in the Medicare Program for things that are not covered by Medicare today, and that is not acceptable.

General revenues are already paying 36 percent of the cost of Medicare, and I think that is not acceptable. You look at the 77 million baby boomers that are coming on to the program. The program, in its current state, is not acceptable. It does need major reform. And this should be the opportunity to add prescription drugs and at the same time do something on real reform. Senator Moy-

nihan has said that prescription drugs and reform have to be linked together.

The Breaux-Frist 2000 measure—which Dr. Frist and I have now presented—is an outgrowth of the Medicare Commission and is a version of S. 1895, which was the Breaux-Frist Comprehensive Medicare Reform With Prescription Drug bill that we introduced. Recognizing that we probably only have 30 days left before we are out of here and the elections are begun, we are not going to be able to do any major reform of Medicare plus prescription drugs.

But what we have outlined in Breaux-Frist 2000 I think is a major step in the right direction that hopefully we can agree on. We create, as Congressman Thomas does, an outside-executive branch agency to run both Medicare+Choice as well as run the new prescription drug program. Medicare+Choice is not working, and for many it is an unmitigated disaster. It is overly regulated, reimbursements are too high in some areas and not high enough in others. So we would put Medicare+Choice under the new agency, allow them to run it based on competition, as well as running the prescription drug plan.

Our prescription drug plan is subsidized across the board at 25 percent. It is income-related, which means it is means tested for upper-income seniors. For everybody under 135 percent of poverty, it is 100 percent subsidized and is ratcheted down from 135 percent up to 150 percent on a scale declining to 25 percent.

We think that it will work. We create a reinsurance pool much like Congressman Thomas does to pay for catastrophic costs. We also allow the insurance to provide coverage for the out-of-pocket expenses as well as for the prescription drugs. We also require that people have to sign up early, like they have to do for part B, to make sure they get into the new prescription drug program.

The final point is—very quickly—don't set a deductible and a copayment in legislation. Our plan calls for a prescription drug plan of an $800 actuarial value. You could come up with all kinds of combinations under that. If you set the specific deductible and the specific copayment, every year Congress will be coming back trying to lower the copayment or increase the deductible or vice versa. That is not the way to do it. I would suggest an $800 actuarial value and let companies offer different variations and people pick the one that best suits them.

Thank you, Mr. Chairman.

[The prepared statement follows.]

Statement of Hon. John Breaux, a United States Senator from the State of Louisiana

Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify today on an issue critically important to the health of our nation's seniors—prescription drugs. As you know, last November, Senator Bill Frist and I introduced legislation, S. 1895, along with Senators Kerrey and Hagel, to strengthen and improve the Medicare program and provide a long-overdue outpatient prescription drug benefit. Much of what we proposed in S.1895 reflects the policies supported by a bipartisan supermajority of the Medicare Commission which I had the privilege to co-chair with the Chairman of the Ways and Means Health Subcommittee, Congressman Bill Thomas. However, given the limited number of legislative days remaining in this Congress and the difficulty of passing comprehensive Medicare reform this year, Senator Frist and I recently outlined an incremental, bipartisan Medicare proposal (Breaux-Frist 2000) that we believe represents an important down payment on Medicare reform and prescription drugs.

The following is a comparison of S.1895 and the incremental Breaux-Frist 2000 proposal.

	S.1895 (Medicare Preservation and Improvement Act of 1999)	Breaux-Frist 2000
Administration	Independent Medicare Board	New executive branch Medicare agency with advisory board (similar to SSA).
Competition	Premiums linked to national weighted average.	Premiums linked to fee-for-service.
Drug Benefit	Drug benefit through high option plans with minimum acturial value. Approved by Medicare Board..	Drug benefit through existing M+C plans and private entities with minimum acturial value; reinsurance program to assist with high-cost cases; overseen by new Medicare agency..
Drugu Subsidy	Full low-income subsidies up to 135%; sliding subsidy 135–150%; universal 25% subsidy over 150%..	Same.
Solvency	Unified trust fund; general revenue funcing limited to 40% of total program costs..	A and B Trust Funds remian separate; no trigger to general revenues; new measures to gauge Medicare solvency..

I have said many times and I continue to believe that we must use the addition of a prescription drug to benefit to Medicare as an opportunity to make important structural changes to the program. To quote my wise friend and colleague Senator Moynihan: "Medicare reform is the price we must pay for prescription drugs."

Adding a new drug benefit to Medicare by itself removes what little political incentive exists to do the heavy lifting needed to reform the underlying program. That is why it is so critically important that the issues of reform and prescription drugs be linked. We need to fix Medicare now so that we can keep the promises we've already made to seniors, before we make a new promise in the form of a prescription drug benefit.

As we address the addition of a prescription drug benefit this year, we should not overlook the problems Medicare faces today. The facts bear repeating. Today, we know Medicare:

• Will continue to consume an increasing share of the federal budget, reaching 25% by 2030;

• Only covers 53% of seniors average health care expenses. According to AARP, Medicare beneficiaries spent approximately $2,430, or 19% of their income, out-of-pocket for health care in 1999.

• Will continue to grow by an average of 6.9% over the next 10 years, doubling spending from $208 billion today to more than $400 billion in 2010;

• Relies on general revenues to pay for 36% of total program expenditures and will continue to use an increasing share of general revenues, leaving fewer and fewer federal dollars available to support other federal programs;

• Faces a demographic tidal wave with 77 million baby boomers becoming eligible for Medicare beginning in 2010.

OVERVIEW OF BREAUX-FRIST 2000

Real Competition to Fix Medicare+Choice

Breaux-Frist 2000, which we plan to introduce later this month, lays the foundation for the kind of reform I believe will ultimately be necessary if Medicare is to be sustainable in the long-term. First, it takes steps to stabilize a Medicare+Choice program which is clearly on life support. Medicare+Choice is a take-it-or-leave-it system with reimbursements that are too high in some counties and too low in others. It is also a program regulated by an agency that knows little about private sector, market-based health care delivery.

In Breaux-Frist 2000, we allow plans to set their premiums each year rather than waiting for government-administered reimbursements. But beneficiary premiums

under Breaux-Frist 2000 would be linked to the cost of the HCFA-run fee-for-service plan so beneficiaries in fee-for-service won't pay a higher Part B premium than they otherwise would under current law.

New Medicare Agency

Today, the Health Care Financing Administration (HCFA) runs the fee-for-service and Medicare+Choice programs, and controls the terms of competition between private plans and the HCFA-run fee-for-service plan. As illustrated in the attachment, Breaux-Frist 2000 would establish a new executive branch agency outside of HCFA and the Department of Health and Human Services (HHS) to oversee Medicare+Choice and the new prescription drug benefit.

Like the Social Security Independence and Program Improvements Act of 1994, which moved the Social Security Administration (SSA) outside of HHS, this new entity will be an executive branch agency, with a Commissioner appointed by the President and confirmed by the Senate. Our proposal would also create an advisory board within the new Medicare agency to advise and make recommendations on Medicare policy. HCFA would continue to run Medicaid, the State Children's Health Insurance Program (SCHIP), and the fee-for-service program in which 83% of seniors currently participate. The new Medicare agency, and a change in HCFA's role and mission, are the critical down payment Congress must make if it passes prescription drug legislation this year.

Universal Prescription Drug Benefit

As I've said many times, prescription drugs are as important today as a hospital bed was 35 years ago when Medicare was first established. The growing importance and increased use of prescription drugs have had a disproportionate effect on the elderly, who account for 13% of the population, but more than one-third of the nation's total drug expenditures.

I strongly believe that one of the reasons we don't have a prescription drug benefit in Medicare today is because of the rigid, government-administered pricing system, which is micromanaged by Congress and slow to adapt to changing health care needs and technologies. No government program can possibly keep up with the increasingly rapid rate at which new life-saving and life-improving drugs and technologies are brought to the market. That is why I have serious reservations about giving HCFA any pricing, management or administrative role over a new prescription drug benefit in Medicare. Moreover, simply using private contractors like pharmacy benefit managers (PBMs) in a given region is no different than how HCFA currently contracts with fiscal intermediaries and carriers to deliver Part A and B benefits.

Breaux-Frist 2000 provides affordable and accessible outpatient prescription drug coverage for all beneficiaries and ensures seniors have access to the latest pharmaceuticals. Under our proposal, all Medicare beneficiaries will have access to an outpatient prescription drug benefit meeting a minimum actuarial value. Beneficiaries enrolled in Medicare+Choice will be offered the prescription drug benefit through the plan in which they're enrolled. Beneficiaries in fee-for-service Medicare would select a drug benefit offered by new private supplemental plans. Subject to approval by the new Medicare Agency, these new private plans could also offer stop-loss protections and additional benefits such as dental, vision or long-term care.

To help with catastrophic drug costs, Breaux-Frist 2000 establishes a reinsurance pool, setting aside a specific dollar amount each year to help subsidize plans for their highest costs prescription drug cases. This in effect provides an additional reduction in drug premiums for all beneficiaries. This reinsurance concept is very similar to the one recently proposed by Chairman Thomas and other House members. In addition, seniors would be protected against catastrophic drug expenses through new stop-loss protections.

Some have argued that public financing of private coverage won't work and that a one-size-fits-all HCFA-managed benefit is the only option. I disagree. Breaux-Frist 2000 contains several features I believe will make private coverage of prescription drugs work for seniors.

First, strong government oversight and substantial public funding give seniors and plans a strong incentive to participate. Second, funding for reinsurance will help health plans with their highest cost drug cases and a one-time enrollment feature will help attract a diverse pool of enrollees. Finally, Breaux-Frist 2000 contains a fallback provision, as S.1895 did, that charges the Medicare Agency with guaranteeing all seniors have access to a prescription drug benefit in those areas where private sector participation does not materialize. Regardless, adverse selection or a lack of plan availability could not be worse under a reformed system than they are under current law, especially for seniors who need drug coverage.

Under Breaux-Frist 2000, all beneficiaries will receive a subsidy toward the purchase of drug coverage. Low-income beneficiaries below 135% of the federal poverty level (FPL) will receive a full subsidy for the lowest cost comprehensive or supplemental plan; beneficiaries between 135%–150% FPL will receive a subsidy based on a sliding scale, phasing down from a 50% subsidy at 136% FPL to a 25% subsidy at 150% FPL. Breaux-Frist 2000 also provides a 25% universal subsidy toward coverage for all beneficiaries over 150% of poverty. These premium subsidies would be treated as taxable income, reducing their final value somewhat for more affluent seniors.

Coverage: The Key to Affordable Prescription Drugs

The key to providing affordable prescription drugs to seniors without stifling innovation and competition is through coverage. Any time members of Congress or their staff need a prescription filled, they take their prescription to a pharmacy and, if they're in a managed care plan, they most likely pay only a $5 or $10 copayment. If they pay coinsurance for each drug, they will still pay less than retail as a result of lower prices negotiated by insurers which are passed along to consumers. Seniors and others without prescription drug coverage pay the full retail cost set by individual pharmacies. Since no insurer is negotiating discounts on their behalf, these Americans end up paying the most for prescription drugs. But, if they had coverage and an insurer or PBM to negotiate lower prices, they would reap the benefit of lower prices which other insured Americans enjoy.

There has been much discussion regarding drug pricing and the availability of drugs at lower prices in other countries, such as Canada and Mexico. Some have advocated using Canadian cost containment policies as we design a prescription drug benefit for America's seniors. But any price controls, whether implicit or explicit, will have devastating, long-term consequences for the development of new medicines that allow us to lead longer, healthier, more productive lives. Price controls are not the answer-providing seniors coverage for prescription drugs is.

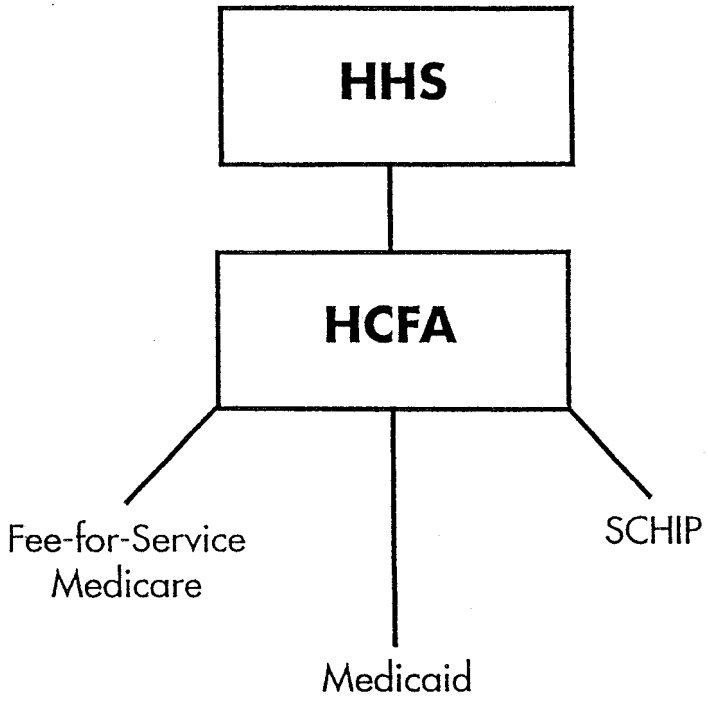
New Measures of Medicare Solvency

Under Breaux-Frist 2000, the Part A and B Trust Funds would remain separate. New mechanisms will be established so Medicare's financial health is measured by looking at total spending and revenues for the entire program as opposed to only looking at the balance in the Part A Trust Fund. These measures would be used to sound an early warning and trigger debate as to policy decisions necessary to financially sustain Medicare.

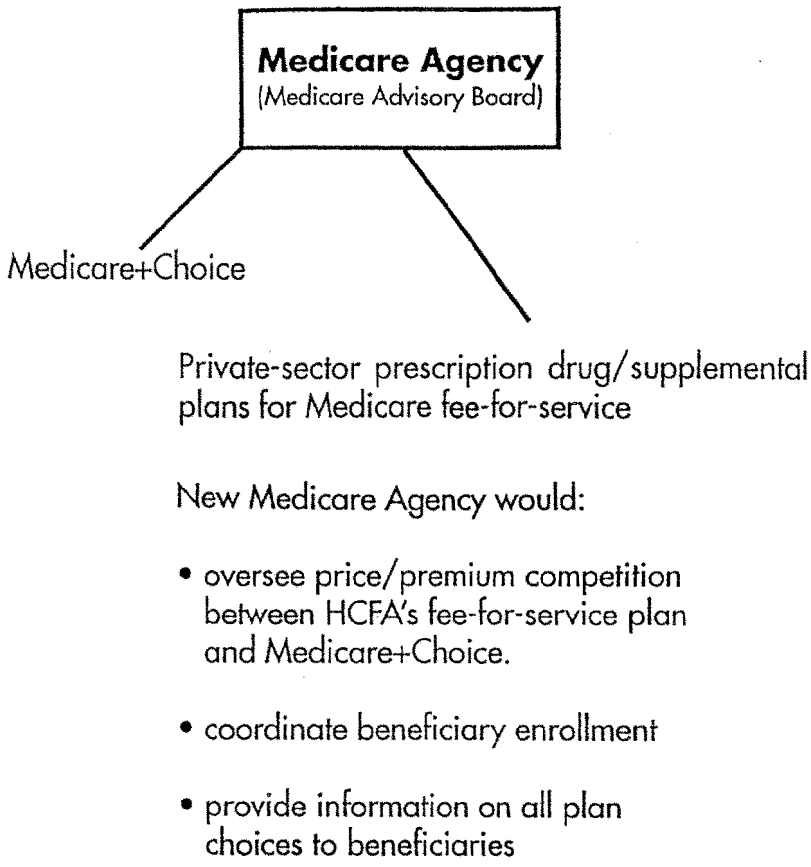
Conclusion

The overwhelming public support for an outpatient prescription drug benefit gives us a real opportunity to make Medicare better with bipartisan legislation. Seniors absolutely need prescription drug benefits, but adding prescription drugs without addressing the underlying program will only worsen Medicare's financial deficiencies and administrative inefficiencies.

Medicare must be modernized and put on a sound financial footing to be able to provide seniors with a drug benefit that is an integral part of their health care plan. I believe we should use this opportunity to pass meaningful, bipartisan legislation and take an important first step toward an improved Medicare for all Americans. Thank you again for the invitation to appear before this committee and I'd be happy to answer any questions.



HCFA would continue to administer fee-for-service and all other non-Medicare functions.



Chairman ARCHER. Thank you, Senator Breaux.

Our next witness is a member from our own body, the gentleman from Minnesota, Mr. Peterson.

STATEMENT OF HON. COLLIN C. PETERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. PETERSON. Thank you.

Good morning and thank you, Mr. Chairman and Ranking Member Rangel, for inviting me to testify today before you on this important issue.

Medicare has delivered quality health care for over 30 years, but most everyone agrees that it needs to be reformed for the future. I want to agree with my colleague here, Senator Breaux, that we ought not to add a drug benefit without getting some kind of reform in the system.

I also want to associate myself with most of his remarks because basically where he is, is very close to where Congressman Thomas and I are, and that is as Congress and the public discuss Medicare

reform—specifically the addition of a prescription drug benefit—the debate has predictably evolved into a highly politicized one, which I think is real unfortunate. I have been concerned for some time that it has become so politicized that Congress will fail to produce a proposal that has a real chance to become law. Unfortunately, the real losers in this political battle are the people who need the help the most.

Today, I believe this debate has received an important second wind because this morning myself and a team of bipartisan colleagues—Congressman Thomas, Ralph Hall from Texas, Richard Burr from North Carolina—announced a plan that would offer a voluntary and universal prescription drug benefit to American seniors. This new entitlement would provide affordable prescription medicines to Medicare beneficiaries and provide much needed reforms to the Medicare+Choice Program.

For the past few years, I have been working toward a solution that would not only provide a prescription drug benefit for all seniors, but also guarantee affordable and accessible medicine for rural seniors. While the Medicare+Choice Program conceived in 1997 has increased access in some regions, Rural America has been left behind.

I believe the measure we announced today has the best shot we have in offering universal prescription drug coverage to all seniors, regardless of where they live. Our measure satisfies the principles, I believe, necessary for Medicare prescription drug benefit. As I stated, the plan provides a voluntary universal prescription drug benefit by making it available to everyone. No senior will fall through the cracks. And moreover, by making it voluntary, we protect seniors who are happy with their current coverage.

Like the President's plan, the low-income folks are fully subsidized. All Medicare beneficiaries will receive a subsidy, which will help keep the cost of their benefits more affordable. And a stop-loss provision provides seniors with the peace of mind that Medicare won't abandon them when they are the most sick.

Additionally, the measure provides safeguards for Rural America. Rural districts across the country, including my own in Northwestern Minnesota, suffer from acute deficiencies in health care and reimbursements. Any Medicare reform needs to recognize these problems and close the funding discrepancies in health care between the rural areas and some urban areas.

To that end, our plan reforms Medicare+Choice and thereby increasing incentives for private plans to participate in the rural areas. While I am hopeful that the reforms of Medicare+Choice will accomplish the goal of expanding access to prescription drugs, quite frankly, I have been around long enough to remain concerned that these reforms could fall short, especially in Rural America, given what has happened in the past.

Other aspects of our plan that will increase the likelihood that carriers will offer prescription drug coverage in new markets include subsidies for drug plans and Federal exemptions for State licensing requirements for companies who desire to expand their coverage area. If these incentives fail, and there are not at least two plans operating in any particular area, the new Medicare Benefits Administration—which is newly created that will operate within

the Department of Health and Human Services—will be responsible for administering the benefit.

This aspect of our plan should bring peace of mind to all seniors, especially seniors who are without quality and affordable prescription drug coverage because of where they live. Thus, if market forces do not prevail, Medicare beneficiaries in Rural America will not be left behind with this legislation.

This legislation is consistent with my philosophy of a middle-of-the-road, common-sense solution to important policy questions. I believe it is truly the best approach and can be done without risking the financial health of the Medicare Program.

Mr. Chairman, I look forward to working with all of you and thank you for the opportunity to testify before the Committee.

[The prepared statement follows.]

Statement of Hon. Collin C. Peterson, a Representative in Congress from the State of Minnesota

Good morning. Thank you Mr. Chairman and Ranking Member Rangel for inviting me to testify today on this very important issue.

Medicare has delivered quality health care for over 30 years, but everyone can agree that it needs to be reformed for the future. As Congress and the public discuss Medicare reform measures—specifically, the addition of a prescription drug benefit—the debate has predictably evolved into a highly politicized issue. I've been concerned for some time now that it has become so politicized that Congress will fail to produce a proposal that has a real chance to become law. Unfortunately, the real losers in this political battle are the people that need help the most.

Today, I believe this debate has received an important second wind. This morning, myself and a team of bipartisan colleagues—including Congressman Bill Thomas, Congressman Ralph Hall, and Congressman Richard Burr—announced a plan that would offer a voluntary and universal prescription drug benefit to American seniors. This new entitlement would provide affordable prescription medicines to Medicare beneficiaries and provide much needed reforms to the Medicare+Choice program.

Over the past few years, I have been working towards a solution that would not only provide a prescription drug benefit for all seniors, but also guarantee affordable and accessible prescription medicine for rural seniors. While the Medicare+Choice program conceived in 1997 has increased access in some regions, rural America has been left behind.

I believe that the measure we announced today is the best shot we have in offering universal prescription drug coverage to all seniors regardless of where they live.

Our measure satisfies the principles I believe necessary for a Medicare prescription drug benefit. As I stated, our plan provides a voluntary and universal prescription drug benefit. By making it available to everyone, no senior will fall through the cracks. Moreover, by making it voluntary, we protect seniors who are happy with their current coverage.

Like the president's plan, the low-income are fully subsidized. All Medicare beneficiaries will receive a subsidy, which will help keep the cost of the benefit affordable. And a catastrophic benefit provides seniors with the piece of mind that Medicare won't abandon them when they are the most sick.

Additionally, the measure provides safeguards for rural America. Rural districts across the country, including my own in Northwestern Minnesota, suffer from acute deficiencies in health care. Any Medicare reform needs to recognize these problems and close the discrepancies in health care between rural and urban areas.

To that end, our plan reforms the Medicare+Choice program thereby increasing incentives for private plans to participate in rural areas. Increased participation in the Medicare+Choice program is an important step in increasing prescription drug accessibility for all Medicare beneficiaries.

While I am hopeful that the reforms to Medicare+Choice will accomplish the goal of expanding access to prescription drugs, quite frankly, I've been around long enough to remain concerned that these reforms could fall short—especially in rural America.

Other aspects of our plan that will increase the likelihood that carriers will offer prescription drug coverage in new markets include subsidies for drug plans and federal exemptions from state licensing requirements for companies who desire to expand their coverage area.

If these incentives fail, **and there are not at least 2 plans operating in any particular area,** the Medicare Benefits Administration—the newly created entity that will operate within the Dept. of Health and Human Services—will be responsible for administering the benefit. This aspect of our plan should bring piece of mind to all seniors—especially seniors who are without quality and affordable prescription drug coverage just because of where they live.

Thus, if market forces do not prevail, Medicare beneficiaries in Rural American will not be left behind.

This bipartisan legislation is consistent with my philosophy of middle of the road common sense solutions to important policy questions. I believe it is truly the best approach and can be done without risking the financial health of the Medicare program.

Thank you again Mr. Chairman for inviting me to testify before the committee.

Chairman ARCHER. Thank you, Congressman Peterson.

Our next witness is our colleague from California, the gentlelady Anna Eshoo. We are happy to have you before the Committee and you may proceed.

STATEMENT OF HON. ANNA ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. ESHOO. Thank you, Mr. Chairman. Good morning to you, to our Ranking Member, Mr. Rangel, and to all the distinguished Members of the Committee.

You have my printed testimony, so I am going to summarize since you have listened to almost all of us with patience this morning on this most important issue of not whether we should provide prescription drug coverage for the seniors of our Nation, but rather how to.

There are some in Congress who think we should turn the problem over to the private insurance industry. I am not one of those that belongs to that school of thought. I don't know what is happening in your congressional district, but daily I receive telephone calls and letters and e-mails from my constituents. They are frantic because the private insurance market is pulling out from under them.

Others believe that the Federal Government should really limit how much drug companies can charge. I don't believe in price controls and the legislation that I have introduced does not mirror that thought. I really believe that if we don't have competition, or if we stifle it, patients will be at risk in terms of the access of what will be brought to market.

Startup companies won't have an incentive to do what they do very well. I think just about everyone here has traipsed through my congressional district. It has the largest concentration of biotechnology companies, not only in California but in our country and in the world. So I think we have a responsibility to work with those that really possess so much of the intellectual property that is out there and what they are doing.

My legislation really builds on the President's plan. It is the Medicare Prescription Drug Act of 2000, H.R. 4607. It stays true to the hallmark of the Medicare Program by providing a generous, defined benefit package that is easy for seniors to understand. Yet

I think we took a step into the future by introducing private sector competition.

It would be available to all Medicare beneficiaries and the Federal Government will pay half of an individual's drug costs up to $5,000 a year when fully phased in. For seniors whose out-of-pocket expenses exceed $2,500 in drug expenditures, the Federal Government will then stand next to them.

PBMs will deliver the benefits and seniors will choose among multiple options, much like we do today in the Federal Employees' Health Benefit Plan. I have used models that already work. So I don't use a lot of theory in the legislation, but rather models that work.

By allowing multiple PBMs to use the same tools that have made them successful in reducing costs and promoting quality for employees in the private sector, my bill will, for the first time, introduce open competition into Medicare, reduce prices, and increase consumer choice.

I am going to bring my testimony to a conclusion. Let me just summarize that it is universal, it is voluntary, it will improve efficiencies. We don't create Federal bureaucracy, which has been described at the witness table, but rather place the responsibility not in HCFA for the administration of the plan, but in OPM.

The Office of Personnel Management does a superb job in administering the plan that we are all a part of today. And it is the largest in the country, as you well know. There are pricing efficiencies by injecting competition, as I have described, through the PBMs. There is a stop-loss provision. The President's plan stops there. I think it is important to do that. And I think that it is very fair because we recognize in the legislation that there are those that simply cannot afford to pay anything. We will stand next to them.

Those that earn less than 135 percent of poverty, do not pay any premiums or co-pays.

In the words of FDR—and I think that they are important words to recall today because I consider today's hearing somewhat historic—"never before have we had so little time in which to do so much." It is up to the Congress to come together around a universal plan and stand next to seniors because we know that what is out there today, in many cases, is not working and that the majority of seniors do not have any coverage whatsoever.

Thank you, Mr. Chairman and all the Members of this Committee. It really is a privilege to come before you and testify on an issue that I think in our day and time we can really do something about.

[The prepared statement follows.]

Statement of Hon. Anna G. Eshoo, a Representative in Congress from the State of California

Thank you, Mr. Chairman and Members of the Committee for the opportunity to testify before you today regarding the very important issue of how we create a Medicare prescription drug benefit.

When Medicare was created in 1965, seniors were more likely to undergo surgery than to use prescription drugs. Today, prescription drugs are often the preferred, and sometimes the only, method of treatment for many diseases. In fact, 77% of all seniors take a prescription drug on a regular basis.

And yet, nearly 15 million Medicare beneficiaries don't have access to these life-saving drugs because Medicare doesn't cover them. Countless others are forced to spend an enormous portion of their modest monthly incomes on prescription drugs.

Right now, 18% of seniors spend over $100 a month on prescriptions. Seniors comprise only 12 percent of the population, yet they account for one-third of all spending on prescription drugs.

The question before Congress is not whether we should provide a Medicare drug benefit, but *how* to do it.

There are some in Congress who think that the way to do this is to turn the problem over to the private insurance market, but the private insurance market is pulling out from under seniors in the Medigap and Medicare+Choice markets. I receive letters and calls every day from seniors in my Congressional District who are frantic that their Medicare HMO has raised prices, scaled back benefits, or is pulling out of the market entirely. Why should seniors trust the private insurance industry if this is what is happening to them today? Chip Kahn of the Health Insurance Association of America (HIAA), the trade association that represents the health insurance industry, has stated publicly that health insurance companies won't offer Medicare drug-only plans because they can't make enough money. So, I don't believe that the private insurance model will work.

Others believe that the federal government should limit how much drug companies can charge for their products. I disagree. Price controls are anti-competitive and can place patient access at risk. I have the largest concentration of biotechnology and pharmaceutical companies located in my Congressional District and I see every day the capital risk that is inherent in research and development. Start-up companies in my district won't get the capital necessary to develop that next breakthrough Alzheimer drug if the investors know that the federal government is going to cap how much they can charge for it.

I've introduced legislation that builds upon the President's plan by incorporating open competition and reduced administrative inefficiency. My bill, The Medicare Prescription Drug Act of 2000 (H.R. 4607), stays true to the hallmark of the Medicare program by providing a generous, defined benefit package that's easy for seniors to understand; yet we took a step into the future by introducing private-sector competition. The result will be a more affordable drug benefit for both beneficiaries and the Federal government.

The bill is simple. Available to all Medicare beneficiaries, the Federal government will pay half of an individual's drug costs up to $5,000 a year, when fully phased in. For seniors who exceed $5,000 in drug expenditures—or $2,500 in out-of-pocket costs—the Federal government picks up the whole tab.

PBMs will deliver the benefit and seniors will choose among multiple options much like we do today in the Federal Employees Health Benefits Plan (FEHBP). By allowing multiple PBMs to use the same tools that have made them successful in reducing costs and promoting quality for employees in the private sector, my bill will, for the first time, introduce open competition into Medicare, reduce prices, and increase consumer choice.

According to CBO, if only one PBM is allowed in each region and PBMs are not allowed to offer a selective formulary, there would be little incentive for reduced pharmaceutical costs. Simply purchasing a large quantity of drugs does not drive prices lower in the private sector. Pharmaceutical companies grant discounts when a PBM can show that it increases a company's *market share*.

By contrast, allowing for multiple PBMs, and allowing the PBMs to be more selective about the drugs they offer will result in price competition among pharmaceutical companies. We would also allow PBMs to pass cost savings on to Medicare beneficiaries in the form of lower co-payments. The result would be lower drug prices for beneficiaries and significant savings to Medicare. To ensure patient quality, when only one drug is available for a given disease or condition, the PBM would be required to carry it on the formulary.

We've also removed sole administration of the program from HCFA. HCFA will continue to oversee beneficiary eligibility and enrollment but it can't, by itself, run this program. The healthcare system has evolved rapidly, and regrettably HCFA has not kept pace. HCFA lacks the expertise to run a benefit that relies on private sector competition to control costs.

Fortunately, there is another agency that has expertise interacting with private sector health plans, and has proven that it can administer benefits effectively and efficiently with a minimum of bureaucracy. It's the Office of Personnel Management (OPM)—which runs the widely acclaimed FEHBP. OPM will define market areas, articulate quality and performance standards, and evaluate PBMs—just as it does currently for health plans. OPM will ensure that competition is harnessed to run an efficient benefit of the highest quality. Under OPM's leadership, I'm confident that an efficient and effective competitive benefit can be integrated successfully into the Medicare program.

I'm proud of this legislation and proud of the support it has received to date. Original cosponsors of the bill include a large number of Commerce Committee members and a broad cross-section of the Democratic Caucus—from New Democrats to Blue Dogs to traditional liberals. We agree that the best way to get this done is to provide a generous, reliable Medicare drug benefit for seniors without price controls and without harming innovation.

Congress should enact a Medicare drug benefit. For our Nation's seniors, prescription drugs are not a luxury. During these times of historic prosperity and strength, there is absolutely no reason to be forcing seniors to decide between buying prescription drugs or other necessities of life. I appreciate the opportunity to testify before you today.

Chairman ARCHER. Thank you, Ms. Eshoo.

Our last witness is another one of our colleagues, the gentleman from Maine, Mr. Thomas Allen. Welcome to the Committee. You may proceed.

STATEMENT OF HON. THOMAS H. ALLEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. ALLEN. Thank you very much, Mr. Chairman, Ranking Member Rangel, and all the distinguished Members of the Committee. I appreciate the chance to come before you today and discuss an issue that millions of Americans deal with on a daily basis when they try to make choices between their food and their medicine, between their rent and their medicine, between their other bills and their medicine. They are all following this hearing and this issue with personal interest.

Over 2 years ago, I asked the Democratic staff on the government Reform Committee to do a study in my district and what we found was that on average seniors pay twice as much for their medications as the drug companies' best customers—the big HMOs, the hospitals, and the Federal Government itself buying through Medicare or the VA. In October 1998 we did another study which showed that Mainers pay 72 percent more than Canadians, 102 percent more than Mexicans for the same drugs in the same quantity from the same manufacturer.

The pharmaceutical industry every year sits at the top of the Fortune Magazine ranking of profitable industries. This year, like last, they were number one in return on assets, number one in return on revenues, number one in return on equity. In short, the most profitable industry in the country is charging the highest prices in the world to people who can least afford it, including seniors on a Federal health care plan called Medicare.

In September 1998 I first introduced what is now H.R. 664, the Prescription Drug Fairness for Seniors Act, to give some relief to seniors for this price discrimination. It would allow pharmacists to buy drugs for Medicare beneficiaries at the best price given to the Federal Government. No new bureaucracy, no significant cost to the Federal Government, and discounts of up to 40 percent for our seniors. It would give Medicare beneficiaries negotiated discounts, just as Aetna, Cigna, and the Blue Cross plans all negotiate lower prices for their beneficiaries.

I am pleased that both the House and the Senate have taken steps to cover military retirees over 65 with just this kind of nego-

tiated discount approach. Most of us voted for that in both the House and the Senate.

In my State of Maine, with unanimous support in the State Senate and all but 11 votes in the House of Representatives, the State has enacted a bill that essentially allows Maine to be a pharmacy benefit manager for all those people in Maine who don't have prescription drug coverage, about 300,000 plus people. The State will negotiate lower prices for them.

Seniors, however, need more than a discount. They need a Medicare prescription drug benefit that is affordable and meaningful. They need the assurance—and we as taxpayers need the assurance—that Medicare will get the best price possible in this market. So, therefore, the right approach is a discount and a benefit that are blended together in a structure that allows Medicare to get lower prices for itself and for our seniors.

A prescription drug benefit must be universal and voluntary. It must, in my opinion, be administered under Medicare. It must cover all medically necessary drugs. It must end price discrimination. It must end geographic discrimination. And it is on these areas where I believe the Republican plan falls short.

We have different views of what seniors need. I believe what they need—what they ask me every day when I am in my district—is stability and continuity and predictability and equity in their plan. Medicare gives them that; the private insurance market does not.

I am not satisfied that there are effective cost-control mechanisms in the Republican plan. Mr. Chip Kahn, who has testified in the past, has said that the private insurance industry won't provide stand-alone prescription drug coverage for seniors because it is like ensuring against haircuts. Too many claimants make private insurance not an appealing market.

People have talked about the need for reform. Let me conclude by saying this: We don't need more managed care, more for-profit managed care in Medicare. And that is where some of those who talk about reform want to go. In my State of Maine, managed care is in decline in terms of its appeal to providers and to patients. Last year, almost 400,000 people were simply dropped from Medicare managed care because the HMOs did not make enough money on them.

As I said before, stability, continuity, predictability, equity—those ought to be the guiding principles that will lead us to a plan that will not be changing every year as a plan founded on private insurance would.

Mr. Chairman, I thank you very much for your time and the attention of all the members.

[The prepared statement follows.]

Statement of Hon. Thomas H. Allen, a Representative in Congress from the State of Maine

Mr. Chairman, Ranking Member Rangel, distinguished Committee members, I appreciate the opportunity to testify before you today, and to address an issue that millions of American seniors confront whenever they try to make choices between food and medicine, the rent and medicine, their other bills and their medicine. They are watching this hearing with personal interest.

More than two years ago I asked the Democratic staff of the Government Reform Committee to investigate the high prices paid by seniors in my district in Maine.

We found that on average seniors without prescription drug coverage paid twice as much for their medications as the pharmaceutical companies' best customers: the HMOs, the big hospitals, and the federal government buying drugs for Medicaid or other agencies like the Defense Department.

A later study, released in October 1998, found that seniors in Maine pay 72 percent more than Canadians and 102 percent more than Mexicans for the same drugs in the same quantities from the same manufacturers.

These studies and others, replicated in congressional districts across the country, confirm that many seniors, covered by Medicare for hospital and physicians services, simply cannot afford the third aspect of their health needs: the drugs that their doctors tell them they have to take.

The pharmaceutical industry, year after year, sits at the top of the Fortune Magazine list of most profitable industries in the country. The latest report covering 1999 showed the industry maintained top rankings from previous years: #1 in return on revenues, #1 in return on assets, #1 in return on equity. And the prices they charge to the uninsured in America remain the highest in the world.

In short, the most profitable industry in the country is charging the highest prices in the world to people who can least afford it, including seniors on a federal health care program called Medicare.

Long before this issue became front-page news, in September 1998, I developed the Prescription Drug Fairness for Seniors Act, H.R. 664, to give seniors some relief from the price discrimination practiced by the pharmaceutical industry. We have 153 cosponsors. The bill is simple. It would allow pharmacists to buy drugs for Medicare beneficiaries at the best price available to the federal government, typically the Veterans Administration price or the Medicaid price. It creates no new bureaucracy. It incurs no significant cost to the federal government. It gives Medicare beneficiaries negotiated lower prices, just as customers of Aetna, Cigna and other private plans receive the benefit of negotiated lower prices.

I was pleased that the House voted last month to give a segment of the Medicare population, military retirees over the age of 65, access to the DOD prescription drug program, which is administered by the federal government and uses negotiating power to give its beneficiaries drug prices equivalent to the best prices obtained by other federal agencies. My bill, H.R. 664, would offer the same negotiated price discounts to all seniors that 353 House Members, including most on this Committee, voted to give to over–65 military retirees.

Since the Senate defense bill includes a similar prescription drug provision, it is almost certain that 1.4 million seniors (military retirees) will by the end of the year gain access to prescription drugs at negotiated prices that are 24–70 percent cheaper than the average private sector price. I hope that this Committee will act to provide similar discounts on prescription medications for 15 million Medicare beneficiaries with no coverage, and avoid making Congress responsible for continuing price discrimination by offering some Medicare-eligible seniors drug price discounts unavailable to other Medicare-eligible seniors.

The State of Maine just enacted legislation to make the State, in effect, a pharmacy benefit manager for all Mainers who don't have prescription drug coverage, seniors and others. Everyone without coverage will get a MaineRx card which will entitle them to pharmacy prices negotiated by the State with the manufacturers. The bill passed unanimously in the State Senate and with only 11 dissenting votes in the State House of Representatives. The concept is embodied in H.R. 664.

Seniors not only need lower drug prices through negotiated discounts, they need a Medicare prescription drug benefit that is affordable and meaningful. Taxpayers need the assurance that Medicare gets the best price for its beneficiaries, so that the program remains cost-effective with the additional drug benefit. That is why blending the benefit and the discount in a process that assures Medicare will have some leverage over price is the right package. In order to be affordable and meaningful, a benefit must reflect the following principles:

- A prescription drug benefit must be *universal and voluntary* so that all Medicare-eligible seniors have access to the program and to avoid adverse risk selection.
- It must be *administered under Medicare.* For three decades, our nation's elderly have relied on Medicare as their health insurer. Medicare covers hospitalization and doctor visits and should be modernized to cover the fastest growing aspect in our health care system, prescription medications.
- It must cover all *medically necessary drugs* so that all beneficiary are guaranteed affordable access to any drug their doctor prescribes for them.
- It must *end price discrimination* by giving beneficiaries access to Medicare's volume purchasing power to negotiate and achieve the same drug price discounts that favored large purchasers obtain.

• It must *end geographic discrimination* by ensuring that beneficiaries in rural areas have access to all benefits and do not suffer when benefit providers change or leave their area.

Seniors deserve a prescription drug benefit that offers stability, continuity, predictability and equity. A program that does not reflect these values will take seniors, and taxpayers, in the wrong direction. With al due respect, I am concerned that the plan proposed by the Chairman of the Health Subcommittee does not reflect these values.

The Republican plan provides subsidies on a sliding scale to give seniors the chance to purchase private insurance to cover prescription drugs. The premium, co-pays and benefit can be changed by the company every year. There are no effective cost control mechanisms, so the taxpayers are not protected. Mr. Chip Kahn, the director of HIAA, has said that the insurance industry won't provide stand alone prescription drug coverage, because it would be like "insuring against haircuts." Too many claimants make this an unappealing market, and 85 percent of seniors take some prescription medication.

If Maine were a low-lying state, and 85 percent of our residents filed a claim for flood insurance every year, we would not be able to buy flood insurance at any price. The same applies to prescription drugs.

We are all aware of the growing problems of the managed care industry in attempting to serve the Medicare population. Last year, almost 400,000 people were simply dropped from Medicare managed care plans because the HMOs did not make money serving them. Medicare HMOs are now charging copayments for drugs, and lowering the amounts of drugs covered.

The Republican plan assumes you cannot trust Medicare and that seniors are better off getting coverage from HMOs and other insurance companies. I believe the plan is better for those companies than it is for seniors. As the Committee debates this plan, I urge Members to ask these questions:

• Can we guarantee that coverage will always be available to all beneficiaries under a private insurance model? Are prescription drugs an insurable product in this market?

• Does relying on Medicare managed care programs offer stability and predictability, given the recent track record of Medicare managed care dropping drug coverage and leaving markets?

• Will a private market prescription drug benefit offer continuity and equity? Are seniors well served when benefits vary widely from plan to plan, and change from year to year depending on the whims of the market and the changes in providers?

• Are there assurances that a private prescription drug policy would be affordable for seniors? Will millions of middle-income seniors who need help with their drug costs be able to get it?

• Does the plan create new bureaucracies and thus add inefficiency and expense?

• Does the plan ensure that seniors won't continue to suffer price discrimination, and provide sufficient negotiating leverage over price so that continued drug inflation (three to four times the overall rate of inflation) does not drain Medicare finances or make drug coverage a product that insurers cannot afford to provide?

• Will attempts to force other countries to raise the prices their consumers pay for prescription drugs necessarily mean that drug prices for American consumers go down, or will additional revenues overseas simply end up as increased profits for U.S. manufacturers? It is fair, moral or even legal to try to use trade law to dictate domestic health policies in other countries?

Seniors need stability, equity, continuity and predictability in their health care plans. They don't get it from for-profit managed care as currently structured. They won't get it from private insurance policies with the premiums, co-pays, benefits or even coverage open to change every year.

We need to keep it simple. Seniors need a universal prescription drug benefit under Medicare with negotiated price discounts that make the program affordable to beneficiaries and to taxpayers. The Democratic plan does this, and the alternatives do not.

Again, I appreciate the opportunity to testify before the Committee and will be pleased to answer any questions.

Prescription drugs can improve, and often extend the lives of people with serious illnesses and chronic disabilities. Recent pharmaceutical breakthroughs offer hope and relief to patients suffering from Alzheimer's, AIDS and other deadly disorders. But the explosion in prices for prescription drugs, coupled with widespread and growing lack of prescription drug insurance coverage, has left millions of Americans unable to afford the drugs their doctors tell them they have to take.

The Need for Affordable Prescription Drugs for Seniors

Prescription drugs, no matter how innovative and effective, provide no benefit to people who cannot afford to take them. Who are the people left behind? Disproportionately, they are many of our nation's seniors.

Congress did not include an outpatient drug benefit when Medicare was created 35 years ago because pharmaceuticals played a much smaller role in health care and were not a significant cost to consumers. But today, seniors, who comprise 12 percent of the population, use one-third of all prescription drugs.

It is estimated that at least one-third of Medicare beneficiaries have no drug coverage at all and must incur these expenditures out-of-pocket. Medicaid is available only to the poor, often driven into poverty by rising medical bills. About 8 percent have Medigap drug coverage. But these plans are too expensive and inadequate for most beneficiaries.

About 17 percent of Medicare beneficiaries have coverage through Medicare managed care. These plans are very unstable. Some are dropping prescription drug coverage. Some are dropping out of Medicare entirely. In 1999 almost 400,000 people have been dropped form Medicare managed care plans. According to a recent report all Medicare HMOs will begin charging copayments for drugs next year. Already 21 percent of Medicare plans limit drug coverage to $500 or less. By next year 32 percent of Medicare managed care plans are expected to have such limits. Seniors deserve more predictability, continuity, stability, and equity than is offered by medicare managed care.

The National Economic Council and Domestic Policy Council report only about one quarter of Medicare beneficiaries have meaningful coverage provided by a retirement plan. Even these plans are even threatened by the high prices of prescription drugs. The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years. Among the largest employers, over one-third have dropped coverage. A principal reason for dropping coverage is that employers cannot afford to pay for prescription drugs.

What does this lack of adequate coverage mean? The General Accounting Office has estimated that the misuse of prescription drugs costs Medicare an estimated $20 billion per year in hospital and physician expenses. The National Economic Council reports that inappropriate use and underutilization of prescription drugs has been found to double the likelihood of low-income beneficiaries entering nursing homes. They report that drug-related hospitalizations accounted for 6.4 percent of all admissions of the over 65 population and that over three-fourths of these admissions could have been avoided with proper use of medications.

Perhaps most importantly, this lack of adequate coverage means that seniors are left to make choices that no one should have to make. Do they pay the rent or take their high blood pressure medication? Do they buy groceries this week or fill their prescription for an osteoporosis drug? We can do better by our nation's seniors.

Seniors are Paying the Highest Prices

As prescription drugs have become an increasingly important component of health care, the pricing practices of drug manufacturers have become increasingly discriminatory toward those least able to afford their products, especially seniors without prescription drug coverage.

Under the leadership of Representative Henry Waxman, who sits on this Subcommittee, the House Government Reform Committee minority staff have spent much of the past year and a half examining the drug prices charged to senior citizens and others who pay for their own drugs. They have conducted studies in over 80 Congressional Districts across the nation. The resulting studies confirmed a shocking pattern of price discrimination.

Not only are seniors in this country paying high prices for their drugs, they are paying more than consumers in other countries. The Government Reform Committee conducted a cost survey of medications commonly used by seniors in the U.S., Canada and Mexico for the same drugs in the same amounts from the same manufacturer. In my district American seniors pay 72 percent more than consumers in Canada, and 102 percent more than consumers in Mexico. Older Americans pay the highest prices in the world for their prescription drugs.

The Industry

The pharmaceutical industry earns more in profits ($26.2 billion in 1998) than it spends on research ($24 billion). Fortune magazine rates pharmaceuticals as the nation's most profitable industry: No. 1 in return on revenues (18.5 percent), assets (16.6 percent) and equity (39.4 percent). The profits of other industries that rely

heavily on research pale in comparison: telecommunications, 11.5 percent; computer and data services, 5 percent; and electronics, 3.6 percent.

In short, the most profitable industry in the nation is charging the highest prices in the world to those who can least afford it, senior citizens without prescription drug coverage.

The Prescription Drug Fairness for Seniors Act

To protect America's seniors from this drug price discrimination, over 130 other members of Congress have joined me to support H.R. 664, The Prescription Drug Fairness for Seniors Act. Senators Edward Kennedy and Tim Johnson introduced a companion bill, S. 731. Our legislation gives Medicare beneficiaries the same advantages that large HMOs and other bulk purchasers like the federal government receive. Currently, virtually all federal health care programs, including the Veterans Health Administration, the Public Health Service and the Indian Health Service, obtain prescription drugs for their beneficiaries at low prices. Our legislation takes the same common sense approach, which is to buy in bulk and save money.

H.R. 664 would allow pharmacies to buy prescription drugs for Medicare beneficiaries at the "best price" given by the manufacturers to the federal government. The best price to the government typically the Medicaid or Veteran's Administration price and, according to GAO, is close to the best price given by the manufacturers to private sector customers. In practice, the federal government would negotiate lower prices for beneficiaries who are already on a federal health care plan called Medicare.

I designed this bill to attract bipartisan support. This bill would not significantly increase federal spending. It creates no new federal bureaucracy. Yet it provides a price discount to seniors of up to 40 percent. While other plans for a prescription drug benefit under Medicare involve substantial expense, my plan involves no significant cost to the federal government or the taxpayers. I believe that H.R. 664 is a fiscally responsible approach relying on free market negotiation to ensure that Medicare beneficiaries get the prescription drugs they need.

The Prescription Drug Fairness for Seniors Act does not impose price controls on the pharmaceutical industry, it ends price discrimination. The bill enables senior citizens to purchase prescription drugs at the same prices the drug manufacturers offer to their favored customers. Rather than imposing a top-down, arbitrary price, the bill leverages the market power of the federal government. Companies can set their best price at whatever level they want and the market will bear. Given our government's social contract with seniors, it is fair and appropriate to use this buying power for the benefit of Medicare recipients, just as we do for other government-sponsored health care beneficiaries.

I understand the need for ongoing research and development in the drug industry. That is why I have supported efforts to extend the research and development tax credit as well as to increase funding for the National Institutes of Health. I am confident that if enacted, H.R. 664 will not force the pharmaceutical industry to reduce research expenditures. Competition within the pharmaceutical industry would assure continued investment.

The historical evidence assures us of continued research and development in this industry. The 1984 Waxman-Hatch Act increased the availability of generic drugs and provided more competition for brand name drugs. Despite the dire predictions of the pharmaceutical industry, the legislation did not stifle or even reduce innovation in the pharmaceutical industry. In fact, pharmaceutical companies more than doubled their investment in research and development, from $4.1 billion to $8.4 billion over the five years following enactment of Waxman-Hatch. Similarly, 1990 legislation that created a drug rebate, requiring drug companies to reduce their prices for drugs sold to the Medicaid program, did not reduce innovation in the pharmaceutical industry. Since 1990, pharmaceutical companies have almost tripled their spending on research and development, from $8.4 billion in 1990 to $24 billion in 1998.

While H.R. 664 is designed to assist all Medicare beneficiaries, it will not solve the problem. Medicare beneficiaries don't just need lower prices for their medications, they need coverage. The President has proposed a benefit, and Representatives Stark, Dingell and Waxman have proposed a benefit. I strongly support these initiatives and believe that it is time to update the Medicare program for the 21st Century and include a prescription drug benefit.

That said, I believe that the Prescription Drug Fairness for Seniors Act complements a prescription drug benefit. We must work to ensure that drug prices are lowered, even in the context of a benefit. With questions about the future viability of our nation's health care program for seniors, this approach will assist seniors without increased burdens on taxpayers.

Conclusion

Chairman Bilirakis, I again want to thank you for holding this hearing today. I realize that you, several of my colleagues on this panel, as well as many members of this subcommittee have proposals aimed at providing seniors with assistance in affording their prescription drugs. I look forward to working together toward a solution that makes prescription drugs affordable for all citizens in this country.

Chairman ARCHER. Thank you, Mr. Allen.

We now go into our questioning period. I am sure there will be many members who wish to inquire.

I really hope we can proceed on this very, very important project without turning it into some sort of a political activity. The Chair is disappointed at the White House's comments yesterday, which really were clearly designed for political reasons, to make a statement about the Committee moving too fast without a bill. This was an unnecessary comment by the White House, instead of trying to work with us to try to create friction. We are going to have a bill and statutory language and there will be adequate time for the members to look at that before the Committee ever marks it up. The Chair is going to insist on that. Hopefully, the White House will work with us and not against us as we walk down this path.

As Senator Breaux said so appropriately, we shouldn't be taking out our political cudgels. We should be taking out our efforts to work together to find an answer to this very important problem.

With that, I recognize Mr. Crane for any inquiry he might like to make.

Mr. CRANE. Thank you, Mr. Chairman.

I was reading an article—and the chairman is looking at it, too—that was in today's issue of Congress Daily. I would like to ask Mr. Thomas to respond to one paragraph in here.

"The report prepared by the White House at the request of Senator Max Baucus argues that rural Medicare beneficiaries are just the sort likely to be disadvantaged by the GOP plan." Could you respond to that?

Mr. THOMAS. Tell my friend from Illinois that the President's plan is just as likely unless they say Medicare is going to guarantee that rural Americans will receive this prescription drug benefit. You have heard it from me and you have heard it from my colleague, Mr. Peterson, that in fact the program we are going to talk about on a bipartisan basis in statutory language guarantees as the insurer of last resort that every American will also have it with government, if necessary.

The key here is that the comments that are being made are an attempt to drive a wedge so that people won't be able to work together in these last few weeks. No one is going to sponsor a Medicare Program under Medicare that is not a benefit, that isn't an entitlement, and that doesn't make sure that every American anywhere has the opportunity to get the prescription drugs if they are a senior and need them. That is not going to be an issue. However, they are going to say it over and over again and the press will report it.

Mr. CRANE. Yet another question, and this is from the same article.

"The White House officials, while admitting that they hadn't seen the details of the GOP plan, nevertheless asserted that those seniors paying premiums would have lower costs under the President's plan than under the proposal to be outlined by the GOP."

Mr. THOMAS. Well, I don't know about the GOP plan, but the bipartisan plan that we are going to present probably will cost a little more than the President's plan because, remember, the President's plan is not an insurance plan. It is a prepayment plan that leaves seniors 100 cents on the dollar obligated for anything over $2,000. You will recall that after the President's plan came out, they talked about adding a year later a catastrophic sometime in 2006. With no structures, Congressional Budget Office can't determine its costs.

More recently, Democrats went to the White House and proposed adding a catastrophic to the President's current proposal. The only problem is that it is triggered by the Secretary of HHS, which means there are no details, which means it has no cost.

What we did was to build an insurance plan with catastrophic from the very beginning under the $40 billion amount that has been provided by the Majority Leadership for Medicare modernization and prescription drug. Any of the proposals—the President's plan adding on in 2006 or the more recent plan adding to the President's plan today—double the cost of the program. Our program will be comprehensive, provide insurance at the affordable cost.

If it costs a couple of dollars more to get full insurance and stop-loss, I think you will find out most seniors are not worried about the first dollar they are going to pay for prescription drug insurance, it is their worry about that last dollar. We provide comfort on that last dollar, the very expensive costs of prescription drugs, from day one.

Mr. CRANE. Thank you.

Chairman ARCHER. The Chair is going to jump in momentarily to ask Senator Breaux, Where, if at any place, do you disagree with the presentation just made by Congressman Thomas?

Mr. BREAUX. I spent a year disagreeing with Thomas on the Commission, and then we came to a conclusion that was pretty much the same after a year of debate.

I think we are very close in the sense that what he is attempting to do is the same as ours in trying to bring about some degree of reform to the program as well as establishing a prescription drug plan.

For those who have a concern about the insurance aspect, I would remind all of us that everyone at this table, and everyone on the Ways and Means Committee, and everyone sitting behind every one of you get their prescription drugs through an insurance plan that is negotiated by the Federal Government Office of Personnel Management. And when you or I or any of our staffs walk to the drug store and the cost of the drug is $100, through our insurance we don't pay $100. We pay a copayment or a deductible. The copayment may be $10 or $15. And that is through a negotiated insurance plan which is available to 10 million Federal employees.

And what Congressman Thomas and what Senator Frist and I have proposed is the creation of a federally structured insurance

plan which provides the same type of coverage to the Medicare beneficiaries. In that sense, we are the same.

Chairman ARCHER. I am a little bit curious because we continue to hear this plan described as the Republican plan. Does that mean that we should welcome you into the Republican party?

Mr. BREAUX. No. I will tell you that I am very serious on this. If we look at this as Republicans and Democrats, we will end up at the end of this year with a debate about whose fault it is that we didn't do anything. Democrats will blame Republicans for not being willing to step forward, and Republicans will blame Democrats for not being able to work with them. And the end result is that the American public will be sick and tired of us fighting with each other instead of joining together to fight for them.

That is the choice we have. Neither plan is going to be perfect, but our challenge is to work it out together, forget about the political arguments, and start arguing about success and who did it as opposed to arguing about failure and whose fault it is.

Chairman ARCHER. Thank you very much.

Mr. Rangel?

Mr. RANGEL. Thank you, Mr. Chairman.

The reason we got stuck with this Republican plan label is because—unlike in past years where Mr. Thomas has worked so closely with Mr. Stark to surprise most people in the Congress—they came and they worked together and they produced their product. With all due respect, Mr. Chairman, to outstanding members in the other body and Democrats outside of this Committee, in the past this Committee used to pride itself with our ability to work on these complex issues and work together. I certainly would not think if the President picked up a Republican to support his initiative that we would reach out and call it a bipartisan effort.

And also, you have to work hard at being bipartisan. It just doesn't happen. And the speed at which we are moving with no bill defies even partisanship. We couldn't get by with this on our side to ask for support when we don't even have the cost of the bill. It is hard to ask questions if you don't have a press release. I assume Mr. Thomas has issued that.

It would seem to me that if the Health Subcommittee, instead of having these exchanges at the hearing, could get together and try to come up with something they can present to the Full Committee that that would be the way you move toward bipartisanship.

But is it true, Mr. Thomas, that you were seriously thinking about marking this bill up on Thursday of this week?

Mr. THOMAS. I tell my friend from New York that a number of the pieces of the bill have not only been aired in front of the Subcommittee over the last year and a half, but a major portion of the reform is in fact a bill that the gentleman from California, Mr. Stark, and the gentleman from California, Mr. Thomas, are cosponsoring.

So there are major components of the reform that are already in legislative form. We are picking up pieces of legislation that have been worked on bipartisanly to form a bipartisan structure.

I am flattered by the Ranking Member's question of me, Do I schedule Ways and Means hearings and do I determine what appears at those hearings? I will tell you modestly, that is not one

of my jobs. That is the chairman and the leadership. I will be pleased and ready at any time this Committee is willing to mark up bipartisan legislation to modernize Medicare and provide prescription drugs for seniors. The sooner the better.

Mr. RANGEL. So I would not be insulting you if I said that you haven't the slightest clue when this would appear before this Committee?

Mr. THOMAS. If the gentleman was to join us on Monday, I believe the schedule is that we will be marking up the bill on Monday.

Mr. RANGEL. Well, that is what I was asking, so you were able to get that.

Mr. THOMAS. I think I read it in the paper.

[Laughter.]

Mr. RANGEL. Could you refer me to what column or item I could read more about your bill? Has that been reported this morning?

Mr. THOMAS. I can give you a number of outlines. I can give you specific structure. And I will be pleased, as soon as our friends at the Congressional Budget Office—and you and I have shared long hours of talking about what excellent work they do and how timely they do it—gives us a score. I would not want to begin a markup here—and we will not begin a markup here—until we know the exact costs, according to the Congressional Budget Office.

It is not an open-ended proposal, Mr. Rangel. It is an attempt to build a credible product of reforming Medicare and providing prescription drugs for the amount that has been provided in the budget, $40 billion.

Mr. RANGEL. So this search for bipartisanship—which the trip should end by Monday before the markup—is on a bill that you and Mr. Stark agree in part with, but the other parts we don't know. They are not locked into place. The costs of the bill we don't know. We don't know how to find out exactly where you end up, but between tomorrow and the rest of the week, we have the weekend to find this bonding and to come up on Monday with a bipartisan solution to this very complex——

Mr. THOMAS. I tell my friend that the price will not be more than $40 billion over 5 years. That was the budget amount. It will be under that. And there are a number of people who have contributed in a bipartisan way.

I mentioned one section, just to let you know that the Chairman and the Ranking Member on the Subcommittee continue to work together and produce legislation where we are able—other members work together as well. We have been working in a bipartisan way for more than a year. Mr. Peterson and I have been working since 1993 together in working out Rural America's health care problems for our seniors.

And a number of those who have a bipartisan stamp on this shows it takes the route of not standing with us at a press conference, and I fully understand why.

Mr. RANGEL. If the President vetoes the State tax bill, we will be saving approximately $50 billion a year. Would that have any impact on the cost of your proposal?

Mr. THOMAS. I will tell the gentleman that I am operating under the budget resolution which says that for Medicare modernization

and prescription drugs there is $40 billion. If somebody wants to provide more money to write a better program in modernizing Medicare, making fundamental changes, you probably could spend more money, but I doubt if you will write a better program.

Mr. RANGEL. Thank you.

Chairman ARCHER. Ms. Johnson?

Mrs. JOHNSON. Thank you, Mr. Chairman.

Thank you all for testifying. I think it is to noted how much solid thinking has been going on on both sides of the aisle and in both chambers on meeting this challenge. It really isn't a question of whether we should provide prescription drug coverage for Medicare, it is just a matter of how we do it because it just essential. Modern medicine without drugs is really not health care anymore.

Let me just ask a couple of questions.

This is an area where truly the devil is in the details. If you look at the commonalities in all the bills, they are very great. One of the differences that strikes me is that a number of the plans you have presented are based on actuarial equivalents. So whether they are insurers, pharmaceutical benefit managers coupled with reinsurers—whoever it is that wants to offer this pharmaceutical benefit—has a lot of latitude in how they do that. On the other hand, in Ms. Eshoo's plan and Mr. Allen's plan—although, Mr. Allen, you didn't really mention the details—it is a defined benefit. That is a very substantial difference.

I would like you to comment, if you would, on that because it is not only a defined benefit, it is a very generous benefit. What is going to be the premium cost to cover 50/50 up to $5,000 with catastrophic covering above $5,000?

And then any of the others of you who want to comment why you chose an actuarial equivalent versus a defined benefit, I would like to hear from you, too.

Ms. Eshoo?

Ms. ESHOO. Thank you. It is a very good question.

The cost of the premium in my plan is approximately $44 a month. It is what the President's plan proposed and the amount of defined coverage that I have in my legislation is the same. Where we differ, of course, is with the stop-loss. The President's plan did not have that.

But I think it is very important—as we are debating who, what, Democrats, Republican, bipartisan, whatever—we have to get into the depth of what these plans are and what kind of an effect they are going to have on people.

In my colleague from California's plan, he relies on the private insurance industry to provide the benefit. In my plan, while we allow private sector competition through the multiple PBMs, the Federal Government is ultimately at risk. Again, I don't think seniors want to be reliant on the private insurance market.

Mrs. JOHNSON. I would like to get to the nature of the insured product later because it is very different from yours, but just to get back to the cost of yours, yours is actually very different from the President's, which is 50/50 up to $2,000. Yours is 50/50 up to $5,000 with stop-loss above that.

So looking at the estimates I have gotten from CBO on other issues——

Ms. ESHOO. The President's is 50/50 up to $5,000 when fully phased in, and the cost of that is a monthly premium of $44.

Mrs. JOHNSON. But that includes no stop-loss. I got separate stop-loss estimates from CBO and they are far higher, at least far higher than you estimate. I do have them here some place and maybe later on I can come back to that.

Here they are. For $6,000, it would be $38 a month. So that would be on top of the $44 a month. So your premium would be quite significant.

Ms. ESHOO. The risk beyond the monthly premium for stop-loss I already stated in the bill provides for—it is the Federal Government that is at risk. I think——

Mrs. JOHNSON. So is there going to be no premium?

Ms. ESHOO. It depends on what kind of investment members want to make in this.

Mrs. JOHNSON. I think it is very important to know what the cost will be if there is going to be no premium and if the government is going to pay the whole cost or what the government is going to pay.

Ms. ESHOO. No, the government doesn't pick up the tab for the whole thing. As I said, up to $5,000, $2,500 out-of-pocket for the beneficiaries, when it is fully phased in, would be $44 a month for that. The stop-loss is included in the $44 premium.

Mrs. JOHNSON. Thank you.

Ms. ESHOO. We do collectively in the system——

Mrs. JOHNSON. Thank you.

Ms. ESHOO.—just as we do in——

Mrs. JOHNSON. Excuse me. I would like to give Senator Breaux a chance to talk about define benefit versus actuarial.

Mr. BREAUX. Thank you, Congresswoman Johnson.

I think the question you have and we all have as well—in writing a prescription drug program, do you spell out in Congress the amount of the deductible and the amount of the coinsurance? Do you want to write that in the law of the country so that every year you come back and have to revisit it and say that it should be lower or higher?

Or is it better to say that we are going to provide an actuarial value of whatever value you want? Then companies can come in and offer some plans with a high deductible, some with a low deductible, some with higher copays and some with lower. Then the beneficiary gets to pick the one that best suits their family.

That is exactly what all of us have. When OPM asked the companies to provide prescription drugs, the only thing they put out in their call is a package of prescribed drugs. And we get all kinds of different options.

I like what Bill Thomas has done because he set a number of deductibles and copayments, but you can vary from that. By setting the copayments, CBO can score that. It is very difficult for them to score just an $800 actuarial value. So if you do what he did and yet give them some flexibility in offering different combinations, I think that may possibly be a good way of doing it.

Mrs. JOHNSON. Thank you very much.

Mr. Thomas?

Mr. THOMAS. Just very briefly—because I don't want to be reported incorrectly—my friend from California, in indicating that our plan relies on private insurers only missed, I think, the point where we said that this is an entitlement and that the Federal Government—under Mr. Peterson's and my bill, and Richard Burr's and Ralph Hall's—will be the insurer of last resort. There is no reliance ultimately on the private plan. We shouldn't put seniors in that position. The government will be there if necessary. We shouldn't repeat ever again that our plan leaves seniors out in the cold if insurers don't participate. That is not the plan. No matter how often people repeat it, that is not the plan.

We believe the private sector can do a great job, but we should never totally leave it to the private sector. We have the government as the insurer of last resort.

Chairman ARCHER. Mr. McCrery?

Mr. MCCRERY. Thank you, Mr. Chairman.

As the law school alma mater of mine and Senator Breaux marches toward yet another college world series title, it is particularly appropriate for me to welcome him today to the Ways and Means Committee.

Mr. BREAUX. I have two alma maters in the world series.

Mr. MCCRERY. I am aware of that, Senator.

[Laughter.]

Mr. MCCRERY. It is a pleasure to have my colleague from Louisiana with us at the Ways and Means Committee today. Senator Breaux is recognized as a leader in the field of health care in policy circles and here on Capitol Hill. It is kind of him to come over and share some of his valuable time with us in the Ways and Means Committee.

Senator Kennedy had to leave—and that is unfortunate—but Mr. Stark is here and has worked with Senator Kennedy, I believe, on his plan so maybe he can clear up the confusion.

Senator Kennedy presented some very colorful charts very quickly, but I was able to catch a couple of the figures he mentioned, as I am sure members of the press and media were, one of which was that the Kennedy plan covers everybody. Of the 12 million people that are currently without any benefit, they will get coverage under the Kennedy plan. Whereas under the bipartisan or Republican or Thomas-Peterson or Breaux-Frist plan there will be 6 million of those 12 million that won't get any coverage.

I would like to know where he got those numbers. Who came up with those numbers? He didn't cite any source for that. He just put them up there for everybody to see.

Mr. Stark, do you know where he got those numbers?

Mr. STARK. No, I don't, but I would presume that he was suggesting that the Republican plan would only cover lower income seniors. That may have changed. Not having a bill, it is a little difficult. But originally some of the early press releases suggested that. It may have been changed. But I believe if that was the case, it would have limited the coverage——

Mr. MCCRERY. That may in fact be the case. But as I have been working on this plan that has now been a bipartisan plan for quite some time—I have been in a number of meetings with a number of Democrats putting together this plan—and as far as I know our

plan was never intended to only cover low-income seniors. However, I will accept that as an explanation of the flawed numbers that were shown by Senator Kennedy in this hearing today.

Mr. Allen?

Mr. ALLEN. I am going to take a stab at answering——

Mr. MCCRERY. That's OK. I think we have the answer to that. Let me talk about your ideas for just a second.

There was a letter sent to the President and Members of Congress by 535 economists from every State in the country in which it was stated that in countries with price controls, health care services are severely rationed. Patients wait months and sometimes years for surgery, suffering significant harm to health and even death as a result.

Government bureaucrats rather than doctors or patients select treatment. Pharmaceutical innovation languishes. Price controls do not reduce medical costs, nor do they call forth improved health care services. Instead, they produce lower quality medical care, reduced innovation, and costly new bureaucracies to monitor compliance, adding to the burdens of health care providers already entangled in red tape. Price controls harm consumers of medical services, especially those most in need of health care services.

Then there is a book written by a Canadian doctor recently. His book won the Donner Prize for the best book on Canadian public policy. The author of that book said recently that price controls in Canada have effectively killed off research and development, adding that the nation relies heavily on the United States work in the pharmaceutical field. It would be very damaging, he said, "in terms of a lack of development of prescription drugs, if the United States imposed price controls." He noted that the biggest medical advances of the past three decades have been in the area of pharmaceuticals.

He said that although some brand name prescription drugs do cost more in Canada, many new drugs are not available in its pharmacies and the generic prescriptions are often more expensive than in the United States.

If 535 economists and a Canadian doctor who has been awarded the Donner Prize say that price controls don't work, why would you want to pursue that course?

Mr. ALLEN. Let me first quickly answer the question before in which I think the difference between the 12 million and the 6 million I think has to do with whether the subsidy under the Republican plan is big enough to attract all the people who don't have insurance now to buy private health insurance. So let me lay that aside.

Mr. MCCRERY. I don't think there has been a good answer to that question, but the fact is that unless you make it mandatory—and you and every other panelist, including Senator Kennedy, has said that this is not mandatory but voluntary—I don't think you can ensure that all 12 million under any plan will be ensured.

Mr. ALLEN. My understanding is that if you provide 50 percent subsidy, you get almost everyone to sign up.

Price controls. Of course, there is great diversity of opinion in Canada as there is in this country about just what the right step is. But if you will look at the publications of Canadian PhRMA,

what PhRMA is saying up in Canada, if you look at the last couple of years of their publications, what they say is that R&D in Canada is accelerating even faster than it is in the United States. And they must presumably have some basis for doing that.

Second, with respect to my legislation, my legislation is not, in my opinion, a price control bill because what it provides is that the best price given to the Federal Government—either the VA price or the Medicaid price—the Medicaid price is a 24 percent statutory discount from something called the average manufacturer's price. The average manufacturer's price is a market price. How a statutory discount from a market price, over which the pharmaceutical industry has more control than anyone else, can be a price control is beyond me. It is not really a price control bill.

Finally, I would say this: The pharmaceutical industry will tell you that half of all new drugs are developed here in the United States. What that means is that half of all new drugs are developed around the rest of the world. There is in fact a vibrant R&D industry going on in Europe and in other places. The real difference between the United States and other countries in terms of spending is not R&D—because you can't really figure that out looking at these multinational corporations' books—the real difference is marketing.

The pharmaceutical industry spends hundreds of millions, if not billions, of dollars here in the United States to market their drugs and they are not allowed to do that to the same extent in other countries. The direct consumer advertising in the country, the ads you see on television, are one reason why the industry costs would be somewhat higher here in the United States than they are in other countries.

But the industry is seeking to expand its sales in other countries. Don't worry. They are doing fine. They are making money. They are by far the most profitable industry in the country. And my bill, according to a Merrill Lynch study, would not hurt their revenues at all.

Mr. MCCRERY. Mr. Chairman, we can disagree over whether Mr. Allen's bill is a price control bill, but many of us think that it is a direct price control by the government and would have serious negative consequences for the golden goose that is laying the eggs in the pharmaceutical industry for seniors in this country.

Chairman ARCHER. The gentleman's time has expired.

Mr. Stark?

Mr. STARK. Thank you, Mr. Chairman.

I guess I would like to see the bill. I have read the press releases on the bill you are working on, but maybe you could help me with a few parameters that you have established in your own mind.

You said a few minutes ago that it was clearly going to be an entitlement. As I have read—and again, this is just what I have picked up in the press—the plan would not be dissimilar from HIJ in Medigap. It would have broad categories of benefits that would be provided and in each State various insurers could price it differently. In each community it might be priced differently. But it would be a plan where beneficiaries could compare plans, and then in any community where there were not two plans—either through

an HMO or through an insurance company, Medigap-type plan—there would be a direct Medicare plan.

Is that roughly what you have in mind?

Mr. THOMAS. That's roughly correct, except when you made the comparison to Medigap you mentioned HIJ—those are the last three of the ten plans.

Mr. STARK. Yes.

Mr. THOMAS. One of the problems with that is that the first dollar by statute says that it has to go down to buy deductibles and copay. We are doing first dollar going to prescription coverage.

Mr. STARK. This would obviously be a completely different plan, but it would be distributed and have regulations or definitions?

Mr. THOMAS. Correct.

Mr. STARK. And it would be sold by private people who could charge different prices for it?

Mr. THOMAS. It would be similar in terms of the fee-for-service program to the President or to the Democrats where you have PBMs or other entities offering it.

The difference, of course, is the President has only one. I believe in competition we would have more than one.

Mr. STARK. For the low-income people, they would be buying the same plan? They would get a direct subsidy and in a sense their premium would be paid directly by the government?

Then for those that are above the various poverty categories, I assume there would be an indirect subsidy, depending on which plan the people pick. Again, as an entitlement, all these payments—the indirect and direct subsidies—would come out of the Medicare Trust Fund? Or would they come out of general revenues?

Mr. THOMAS. I will try to be very brief because I don't want to just use your time, but it does take a while to talk about.

There is a subsidy to all seniors if they voluntarily join the plan. The subsidy is in the government and the private sector shared buy-down of the high-risk pool.

Mr. STARK. That is the only subsidy that an insurance company would get for the non-poverty participants. Is that correct?

Mr. THOMAS. But that is a 30 to 35 percent subsidy that goes to everyone. Then we add on top of that, similar to the President's plan, low income.

Mr. STARK. Where does that money come from?

Mr. THOMAS. That money comes from the money that has been saved over the last several years, the $40 billion.

Mr. STARK. Out of the trust fund?

Mr. THOMAS. No. This is a part B benefit, so it is a general fund part B benefit. That is why there is another provision that talks about restructuring Medicare financing carried over from the Medicare Commission. The current structure really isn't very good.

Mr. STARK. So it comes out of general revenues as Part B——

Mr. THOMAS. Surplus. The decision will be made in terms of cost coming forward.

Mr. STARK. As an entitlement, it is guaranteed just as physician's payments are under Part B?

Mr. THOMAS. That is correct.

Mr. STARK. You have further suggested that the premiums would be $35 to $40.

Mr. THOMAS. When I was asked at the press conference—and that is where that number came from—apparently it doesn't do any good to tell people it is a $740 actuarial value. They want to know what it looks like because they want to compare. Notwithstanding the fact we have a built-in insurance pool and the President doesn't, we still in the bill will create a model or standard benefit, as Senator Breaux said—and those of us who have lived with CBO in getting numbers out of them—they won't score it because they don't know what the actuarial benefit program would look like because it has an infinite number of options.

So if the government is going to pay for the low-income, we provide a model or a standard benefit that would look something like the $35 to $40 premium, the $200 to $250 deductible, 50/50 copay, with the catastrophic attachment. That allows CBO to score. That is representative of a $740 value.

But it could be structured slightly differently. You could have a zero deductible as the President does.

Mr. STARK. If the numbers are right, you are going to get a $740—wherever it comes—let's say it is a $740—they will pay $40 a month, they will pay $480. So you're getting $260 plus they're getting a quarter, approximately, of that $480 or $740 in subsidy, so they'd be getting about $180, $185 on top of the $260——

Mr. THOMAS. I will tell the gentleman that the way he started with the math, it doesn't come out right. I will be more than willing to sit down and work with him——

Mr. STARK. They're getting about $440——

Mr. THOMAS. No, they're getting about an $800 actuarial value, a $740 actuarial value.

Mr. STARK. In exchange for their premium? Or do you add the premium to that?

Mr. THOMAS. No. When you go through and build the premium and the deductible—for example——

Mr. STARK. If I pay the $40 a month, that is $480 a year.

Mr. THOMAS. I prefer $35. I am trying to get it to $35.

Mr. STARK. All right.

Then I am getting a $740 value for that. Is that on top of the $480?

Mr. THOMAS. No. For example, if you paid the $35 premium, you would then be in a—say you did the $250 deductible—you would be in the 50/50 copay up to about $2,200, so you would split that. So there is $1,100 of benefit in the copay area alone, and then you still get the catastrophic attached at the back end. And that is where the heavy 35 percent subsidy comes from in reducing the cost.

All these numbers would be greater if you didn't have the shared insurance provision. People would not be able to afford it, even if they were healthy.

Mr. STARK. Will the premiums be withheld from the Social Security payment as they are for part B premiums?

Mr. THOMAS. In creating the Medicare Benefits Administration, that decision is left to those who are now dealing directly for beneficiaries on the benefit. It is logical that you could then deduct from

your Social Security, as you suggest, the part B premium of a 25 percent subsidy. You could simply attach that, if they so chose. That would be an easy way to deal with it.

Mr. STARK. If somebody missed a premium, how could they get back into the system?

Mr. THOMAS. If they missed the premium, they would obviously be notified by their private insurer. The private sector has the periods of grace periods, penalties, and the rest. All of that would operate as it does in terms of when you miss your payment on your insurance, unless of course you have automatic deduction.

Mr. STARK. Mine is withheld.

But if it is canceled for non-payment because it is not withheld from Social Security—if they are paying it and something happens to them—can they get back in?

Let's say they lose it because they have hard times and they can't pay their premium beyond where the insurance company will carry them.

Mr. THOMAS. I will tell the gentleman that we are way at sea in trying to write legislation if you are going to put down the specific remedy for someone who misses a payment because something happened to them beyond their control. That clearly is an area for the Medicare Benefits Administrator, who is now charged solely with managing the benefits, instead of trying to run it out of the back shop of the Health Care Financing Administration. And they will work in an administrative way to resolve all these problems.

These are the areas where Congress shouldn't be involving itself. We should create a new entity under HHS dealing with benefits to deal with exactly those kinds of questions.

Chairman ARCHER. The gentleman's time has long since expired and——

Mr. STARK. I just want to suggest that my constituents' concern with managed care—which the Republicans have managed to frustrate us from reforming—will not be comfortable with that answer. They don't believe that the managed care or the private insurance industry is going to give them a benefit they can depend on. I think they will treat this much the same as they treat managed care now. They don't trust it. They just feel that for-profit managed care is there to deny the benefits——

Mr. THOMAS. I tell the gentleman we have a fee-for-service prescription drug program.

Chairman ARCHER. The Chair is going to have to cut off this colloquy, as productive as it might be, and encourage the two gentleman who work together on the Subcommittee to continue their discussion about details privately or publicly after the conclusion of this hearing.

The Chair now recognizes Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman. Thank you for holding this hearing.

I want to thank all of you for testifying this morning. There has obviously been a lot of work and informed discussion here today.

I just have a couple of questions.

Ms. Eshoo, I noticed that in your proposal, in your written testimony, and in your statements here today that you don't force beneficiaries in a region into just one pharmaceutical benefit manager.

And in your written statement you talk about options, helping reduce costs, and promote quality for employees.

Can you tell me a little about why you made that decision?

Ms. ESHOO. We all know that a major part of the problem that seniors are facing today is the cost, the high price of drugs. Setting aside any consideration of price controls, what we worked very hard on was to come up with legitimate competition to reduce prices for both the beneficiary and the Federal Government. But we also worked to allow for competition, which I think is really very important to the very small biotechnology companies that are coming up with life-saving drugs.

So it is competition, but it also forces the competition relative to market share.

I think there is a misnomer today about volume buying and that if you buy in volume there are discounts. It really doesn't work that way with the Federal Government today. It just doesn't. But where you make them sharpen their pencils and offer the deepest discounts is by offering them at market share. I believe that is what would bring the pricing down.

I think it is fair, but we also have on the other side of the package a generous benefit.

I also think, most frankly, that the Congress is going to have to come to grips with how much they want to do. If we are going to be skin flints, we should just say so up front. I don't think $40 billion in a plan is going to buy and pay for the kind of package that we want to go home and tell our constituents about.

Mr. CAMP. I am interested, though—your plan and others—Congressman Stark as well has the same model—and your concept of competition and bringing more choices to seniors—so I guess the converse would be true that if there were only one pharmaceutical benefit manager, then there would be a lack of choice and competition and the quality and reduced price that go along with that as well. I presume that is why you chose the model that you did.

Ms. ESHOO. Well, we looked at it. We looked at how they work. As I said in my opening statement, I didn't base the legislation that is supported by a number of Democrats on the Commerce Committee—on theory. I went out to see how things work.

I think that is a very important aspect of the plan. But I also think that Members of the Ways and Means Committee should know that nowhere in my legislation do we rely on the private insurance market for any kind of provision. I don't think that is working, seniors don't trust it, and I don't find that to be a place that we should be moving to because there is a failure out there in the market right now when it comes to private insurance.

Mr. CAMP. I also want to follow up with a question to Senator Breaux.

Senator, your statement also indicates that a one-size HCFA-managed benefit is not really an option that you would support. What are some of the reasons behind that?

Mr. BREAUX. Medicare+Choice is a good example. Medicare+Choice is not working because it is being micromanaged and the reimbursements are based on HCFA policies that are based on fee-for-service fees. Some Medicare+Choice get paid quite

handsomely in some areas. In some counties, they get paid far too low. As a result, they are closing up shop.

So I think what you have to do is create a program that has the benefit of a government oversight, make sure it is run properly, but at the same time get providers to compete against each other and allow them to set their premiums based on what they can provide the services for. What we are suggesting I think accomplishes that.

Mr. CAMP. Thank you very much.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Weller?

Mr. WELLER. Thank you, Mr. Speaker.

Let me begin by commending you and Mr. Thomas and Mr. Breaux, and Mr. Peterson for working in a very, very bipartisan effort to solve a challenge that is before us. Over the last several years I have had a lot of town meetings, particularly with seniors, who talk about the rising costs of prescription drugs and the choices they have to make in setting their household budget priorities. I have heard some pretty heart-rending stories from widows who tell me they have to choose between buying groceries and going to the drug store and buying their prescription drugs. A senior told me that four times a year he takes a shot and it costs him a total of $8,000 for those four shots.

I have also had concerns expressed to me by retirees who are concerned that if we move forward on prescription drug coverage under Medicare they will lose the prescription drug coverage that is offered by their retirement plan, which they feel is better than anything the government can offer.

Those are all concerns that I believe are being addressed in the bipartisan plan that is being offered by Mr. Thomas and Mr. Peterson, as well as Senator Breaux. I commend them for working in a bipartisan way. The prescription drug issue should not be a partisan issue. It should be an issue on which we are working together on affordability, choice, and retention of a better plan if it is offered as part of your retirement plan.

I am just trying to understand how your proposal would affect those retirees who currently have a plan that they like, are happy with, and are satisfied.

Senator Breaux, can you explain how the bipartisan proposal addresses those retirees who are happy with what they have?

Mr. BREAUX. That is a good question. It really deals with how much of a Federal subsidy you are going to have for the prescription drug plan. If you have a subsidy that is too generous, people will drop their private plans. About 33 percent of Medicare-eligible people have their prescription drugs provided by their former employers. The three big auto—General Motors, Ford, and so forth—all have very generous prescription drug plans.

If you create a subsidy so high, companies will drop the plan and let the taxpayer and the Federal Government pay for it. If you have a 50 percent subsidy, you are getting pretty close to that. I think you have probably reached that mark.

Ours is a 25 percent across the board subsidy, plus the reinsurance subsidy that Congressman Thomas has. So we are more generous than Thomas on that issue. We have the reinsurance subsidy plus a 25 percent across the board subsidy.

I think that means that the private offerors will continue to offer those plans for retired workers, and yet they have another option to go into the government-type of sponsored subsidized program. So the two could coexist together.

Mr. WELLER. Senator, one of the concerns often raised about giving seniors a choice—the President proposes a zero-choice plan where you can only accept one thing, which is what the government offers, and your bipartisan plan offers a menu of options offered through private choices, such as Medicare+Choice. Some raised a concern where we have seen Medicare managed care plans have dropped out of Medicare. We have seen that in the Chicago area, which I represent.

As I look at that issue—I know these past few weeks I have been meeting with my local hospitals who are concerned about Medicare reimbursements and the financial impact of how HCFA has interpreted the Balanced Budget Act and the financial squeeze they are under. Is the reason many of these managed care providers—is it a reimbursement issue? Do they have a hard time making ends meet because of——

Mr. BREAUX. We could spend a long time picking out what is wrong with Medicare+Choice. The central problem, I think, is that it is dysfunctional, it is being micromanaged, reimbursement rates in the regulations are based on fee-for-service charges, which means that there are great inequities and some counties are getting more than they need and other counties are getting far less. They can't compete, they can't reduce their premiums, they can only add more benefits to their plans. Therefore, they find themselves getting into trouble.

That is why our plan suggests that the Medicare+Choice, along with prescription drugs, be run through a new independent agency outside of HCFA, like we did with the Social Security Administration. Medicare+Choice cannot continue. I don't think anyone would argue that it can in the way it is being operated now.

Mr. WELLER. Thank you, Senator.

Mr. Thomas, what is the bottom line for a senior? For the typical senior, what will be their potential out-of-pocket costs, on average, each month under the bipartisan proposal?

Mr. THOMAS. I would tell my friend that it is difficult to talk about the average senior. As we know, 28 percent of them get it from their employer. An additional 20 percent get it from Medigap, which is a $2,000 expenditure to get a very modest drug program. Then there are those who don't have any.

So when you are putting a package together, you have to meet all those concerns. For someone who doesn't have any coverage at all, there is no reason in the world why a senior should have to pay retail price for drugs. If Congress can't come to a conclusion in this session, shame on us. They are the last group to pay retail prices. If we had a prescription drug program in place, they would have their costs cut by as much as 40 percent, comparable to what they paying going to Canada now.

But as you indicated with Senator Breaux, if they are getting it from their former employer, you wouldn't want to write a plan that is so rich that that 28 percent would bail over into the Medicare Program. The biggest concern is that high cost. What we do is say

that we will bring in all seniors of Medicare age, including those that are on the private employer's plan, and we will let them share in the risk pool that we have. Relieving employers of the potential of an extremely high risk guarantees they are going to stay in the plan much longer than would otherwise be the case.

When it comes to Medigap, Medigap is simply an out-of-date program that was structured for a different time. There are a number of insurance companies making enormous amounts of money insuring what is basically non-risk. They would love to have that program continue and not have a prescription drug added.

Listen carefully to some of these people who are representing insurance associations and others saying that this plan won't work. Their real fear is that if this plan works, Medigap won't. They like insuring non-risk. They don't like participating in sharing in real risk. That is the responsibility. We will have the government back them up at the bottom end, but if they are not willing to share in riding product of pools risk, there are others who will.

So it is not an average senior. It is a plan that meets all the needs of every senior.

Chairman ARCHER. The gentleman's time has expired.

Mr. Matsui?

Mr. MATSUI. Thank you, Mr. Chairman.

Mr. Chairman, previous members when they were making comments or asking questions referred to the President because some in the administration expressed a great deal of skepticism of the Republican plan. All of a sudden now the President is being attacked for being partisan.

I would like to suggest that because someone might disagree with the Republican plan doesn't necessarily mean that the person is being particularly partisan. And I would hope that we would make sure that when we use that word we use it with perhaps some degree of clarity in the future.

I wasn't going to bring this up, but in view of that fact, I might just mention a few things myself. Apparently, the Republican conference held on June 8th, Glen Bolger, who is a member of a group known as the Public Opinion Strategies—in that Republican conference, it was stated, according to briefing papers, "It is imperative that the Republicans hang together on this issue and pass a bill"—I guess they don't state what kind of bill—"and it is helpful if we can be bipartisan in our approach."

I might just suggest that when you hear the word bipartisan, think focus group because this is not a bipartisan bill. Particularly when you take a look at some of the documents here that was part of the handout at the Republican conference, "The Democratic Plan Has Some Potentially Fatal Weaknesses," and then goes on to state how you can attack. But in the spirit of bipartisanship, I think I will ask Mr. Peterson some questions about the Thomas Republican bill.

You are familiar with the fact that in the proposed document—and again, I only get this from press releases and also from news reports—that the USTR has a role in this particular——

Mr. PETERSON. No, they don't. That has been dropped out.

Mr. MATSUI. Is that correct, Mr. Thomas?

Mr. THOMAS. I would tell the gentleman I don't know what he has been reading, but I can assure you that when you see the bipartisan bill it will look different than the documents that have been given to you in a bipartisan fashion that describe some bill that is not the bill that the gentleman from Minnesota and I will be proposing along with the gentleman from North Carolina, Mr. Burr, and the gentleman from Texas, Mr. Hall.

If you are characterizing a Republican bill, that isn't our bill.

Mr. MATSUI. Is the gentleman then saying that there will be no reference to the U.S. Trade Representative's Office in the proposed legislation when we mark it up on Monday?

Mr. THOMAS. Not in the bipartisan bill.

Mr. MATSUI. Not in your bill? Is that it?

Mr. THOMAS. Not in the bipartisan bill.

Mr. MATSUI. Mr. Peterson, you do understand that in the Medicare+Choice proposal that was instituted in the late nineties that there has been a decrease in enrollment? Are you familiar with that? I guess in 1997 there was a drop of about 300,000 plus.

Mr. PETERSON. That doesn't surprise me. In my area, we have zero and we never will get anything under the current system.

I think the only chance we have of getting any kind of progress in this area is, as the Senator said, get this out of HCFA, get it into some other kind of structure, and improve the payments to areas like mine. If we would take money out of your district and shift it to mine and equalize it, this would work. The problem is that you are getting $800 and we are getting $375. How can that work? And is it fair?

That is the basic problem with this whole situation.

Mr. MATSUI. What is this new cooperation?

Mr. PETERSON. Well, we are going to be increasing on the AAPCC, we will be increasing the amount of money that goes into rural areas. So it is more likely that people will go out there and offer managed care plans.

Mr. MATSUI. How does that happen? I understand that that won't happen and that is why a lot of rural members express skepticism about this program.

Mr. PETERSON. I don't know who is listening to whom, but I have been in the room, working with Mr. Thomas, and I have been working on this. If we would have adopted the budget in 1995, we would have had the money to fix this. But because we screwed around, that 10.2 percent update that could have been used to fix this was given out——

Mr. MATSUI. Maybe you can talk about the current proposal.

How does this actually help rural areas?

Mr. PETERSON. We are going to increase the amount of money that goes into rural areas in the AAPCC. And when we do the updates—I don't know how much I can say about this bill—but there is going to be a bigger update for areas that are getting less money and less money is going to go to areas that are getting more money. So we are going to start to narrow this gap. But the bottom line is that in a lot of parts of this country they are getting prescription drugs because they are getting these huge payments from Medicare. In my area, we don't even have the opportunity because we

are down at these low levels because we have done a good job of holding down costs.

How are we ever going to get this benefit? One of the ways is that in this bill—if this doesn't work and the extra money doesn't bring these managed care plans into my area—what it says in the bill is that we will provide that benefit through this new Medical Benefits Board.

Mr. MATSUI. My time has expired, but——

Mr. PETERSON.—we are not going to get it under——

Mr. MATSUI. The gentleman is taking a pretty big gamble about expecting HMOs to go into the rural areas.

Mr. PETERSON. But I will tell you that the current system is not going to work. It is evidenced by what is going on in my district.

Chairman ARCHER. The Chair is concerned that this panel is going to run, the way we are going, until well after 1 . The Chair would like very much to conclude this panel by 12:30 so that we can take an hour for lunch and return at 1:30 for the next panel. That will require considerable cooperation on both sides of the podium.

The Chair is going to suggest—and I don't have to ask unanimous consent, but I hope that it will meet with unanimous consent—that there be 10 minutes allocated on the Minority side and 10 minutes allocated on the Majority side in order to conclude this panel. There will be plenty of time to question the next two panels that are coming later today.

Mr. Stark?

Mr. STARK. Mr. Chairman, reserving the right for the purpose of inquiring of the Chair, it is my understanding that Ms. DeParle has to leave at 12:45. Would it be possible to extend the 10 minutes per side at least for an additional 10 minutes for her to come in and present her testimony before we adjourn? Otherwise, she will not be able to return.

I would ask if you could adjust your request to allow her time to present her testimony.

Chairman ARCHER. Which witness was the gentleman referring to?

Mr. STARK. The gentlelady who is the Administrator of HCFA. She has to leave at 12:45.

Chairman ARCHER. The problem with that—and I would say to the gentleman—and I accept that as a constructive suggestion—the problem is that if she is simply going to speak and then leave, it seems to me that is not a desirable situation, either.

I would hope that maybe—we could take her later in the afternoon if she could come back at a later time and I will be happy to try to accommodate that. But I would want her to be here beyond just making a short presentation and then leaving.

Could that be accommodated?

Mr. RANGEL. Reserving the right to object, Mr. Chairman——

Chairman ARCHER. Well, if we can't have an agreement to try to conclude here—now we have spent a couple of minutes talking about this—by 12:30, we will just let this panel go on in normal order and continue to let everybody question.

Mr. RANGEL. But you want unanimous consent. Is that it?

Chairman ARCHER. Actually, the Chair does not have to ask unanimous consent, but the Chair wants to be sure that everybody is accommodated.

Mrs. JOHNSON. Mr. Chairman, could I just ask unanimous consent and ask the indulgence of my colleagues?

I think it is really very important to hear the Administrator and have at least a little time to question her. I would like to ask—if I had known, I would have foregone questioning myself—but would members be willing to forego all questioning of this current panel since they are with us in our daily lives?

Mr. THOMAS. We would be happy to leave.

[Laughter.]

Chairman ARCHER. I thought that would accommodate the panelists, too, to a degree.

But apparently we don't have any consensus, so we will just continue right straight on through and let every member have a chance to inquire and use their 5 minutes.

At this point, the Chair recognizes Mr. Lewis.

Mr. Lewis yields back his time.

Mr. Ramstad?

Mr. RAMSTAD. Mr. Chairman, I am not going to take my full 5 minutes, but I do want to make a fundamental point.

I want to thank the members of this distinguished panel for being here today and to those of you who are trying to work in a bipartisan, pragmatic, common sense way to craft a solution to what I deem Minnesota seniors' number one problem and certainly the number one problem of America's Medicare beneficiaries as well.

I certainly agree with what my friend and colleague, Collin Peterson of Minnesota, said. It is unfortunate that the debate has become so politicized. I do note that the invited witnesses here—six Democrats and one Republican comprising this panel—I applaud our leadership's effort to depoliticize this issue. And I know Mr. Thomas and those of us on the Task Force have tried to be bipartisan. I appreciate certainly above all Senator Breaux and Collin Peterson and the rest of you trying to work in this collaborative fashion.

This is really critical that we get something done this year. Forget the political issue. We need a solution. And I thank you, Collin, for putting the best interests of Minnesota seniors above politics. I know, not from you but from some of your colleagues on the other side of the aisle, how much heat you have taken for reaching out and trying to solve this problem. I appreciate that. I want you to know that.

I also want to make the point that any plan we consider must stabilize the Medicare+Choice option for the reasons you stated, Collin. We know only too well in cost-efficient, low-reimbursement States like Minnesota what is happening. Minnesota seniors and Minnesota providers are being cheated $450 in Hennepin County, which is a little bit better from the seventh district, which you represent. But as Durenberger used to say, there is no reason why you should be able to get two and a half Medicare surgeries at the Mayo Clinic in Rochester, Minnesota for every one in Miami, Florida. That is simply wrong and it has to change.

Thank you for not only working on this, Mr. Thomas, Mr. Peterson, Senator Breaux, and the rest of you, but for realizing that we have to do it within the context of Medicare+Choice. These two must remain linked. They are interrelated issues, obviously.

I appreciate the effort that has been forthcoming.

I yield back the balance of my time, Mr. Chairman.

Chairman ARCHER. Mr. Levin?

Mr. LEVIN. Mr. Ramstad, to pick up your comment, I think the test of bipartisanship will be whether there can be an effort within this Committee between now and Monday to craft a bipartisan proposal, and whether on Monday there is one. That will be the test, not whether there are several Democrats out of 200 who join with the chairman of the Subcommittee. The test, so far, I don't think has worked out very well where you have the Ranking Member of the Health Subcommittee asking questions about what is in the proposal.

So I would hope, if we are serious about bipartisanship and not having a political contest here, that there be some effort within this Committee between now and Monday beyond what has happened up to this day.

Mr. RAMSTAD. Would the gentleman yield briefly on that point?

Mr. LEVIN. Sure.

Mr. RAMSTAD. As a member who tries and strives on a continuing basis to be bipartisan wherever I can, I agree with what you said to a point. However, I note on the bill the presence of two Republican sponsors and two Democrat sponsors. I think, if anything I think the message—and let's call a spade a spade—I think the message of bipartisanship should go back to your leadership, putting pressure on members not to work on this because some people here want to keep the issue rather than solve the problem.

Mr. LEVIN. Mr. Ramstad, I take back my time. That is simply not true.

Well, you are working on that assumption, and when you work on that assumption, you move headlong on a basis that doesn't involve cooperation within this Committee.

I have never heard any word from our leadership telling us not to work in this Committee on a bipartisan basis on this issue.

Mr. Thomas, I would like to ask you one question because there is so much confusion about what is in this bill because it is not in written form, yet.

When would the last resort come into operation?

Mr. THOMAS. The last resort provision is where the Medicare Benefits Administrator attempts to create opportunities for plans in areas who don't have any. Obviously, if the Medicare+Choice plan in an area offers the prescription drug benefit and there is the fee-for-service program, then you would have the program. It is only in those areas that haven't been able to attract a program. The Administrator is then required to sit down and negotiate to provide the benefit.

What that negotiation is—whether it is an enhancement, whether it is an assistance in a particular area—is the role that the Benefit Administrator specifically ought to carry out. Just as today in the Federal Employees Health Benefit Program, when you have an administration of a program that seeks to bring the product rather

than restrict the product, you work with those people who are interested, if in fact it is worth their while to sit down and work.

What that is and how it works would be up to the Administrator, so frankly it would be different in different places, Mr. Levin.

Mr. LEVIN. So if there is in place in a particular area a private plan, then there would be no government fall-back plan available to the Medicare recipient?

Mr. THOMAS. In the legislation, if for instance the private plan means an HMO plan or a Medicare+Choice plan, there is a requirement in the legislation that seniors have two choices. So it would be incumbent, then, to bring the fee-for-service prescription drug program to the area as well.

Mr. LEVIN. So if there is one or the other available, then there is no additional available plan.

Mr. THOMAS. No. If there is one or the other, there is a requirement that seniors have at least two choices. So there needs to be two choices, not one or the other.

Mr. LEVIN. They have a choice between one and the other?

Mr. THOMAS. They ought to be able to have a choice, not a one-size-fits-some, but a choice.

Mr. LEVIN. All right. Thank you.

Mr. THOMAS. Thank you.

Chairman ARCHER. Mr. Collins?

Mr. COLLINS. Thank you, Mr. Chairman.

Mr. Chairman, on behalf of my bipartisan constituency, I am pleased that we are moving forward with a process that I hope will resolve a problem for many of my seniors at home who are having to choose between food and drugs. So I look forward to the continuation of this process, and hopefully we will have something in place very shortly.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Watkins?

Mr. WATKINS. Mr. Chairman and members of the panel, Oklahoma is dead last in reimbursement of Medicare in rural areas, the small towns and rural communities. That is totally unacceptable. And I am so thankful there has been some discussion about the rural areas, depressed areas, the forgotten areas of this Nation. I hope—and maybe I can get some interpretation—there is some movement to change that.

Now, we are moving into prescription drugs. Very much needed. My decision is going to be based on a plan that is going to make sure that we are not discriminated against in the small town rural areas again, that we are not second-class citizens, if you please.

We talked about making the decision between having drugs or medication and maybe food or shelter. The fact is that many of them have to leave the small town rural areas in order to try to go get a doctor or get that care.

Can someone give me some kind of assurance that Oklahoma is not going to be dead last again?

Mr. PETERSON. This moves us a long way in the right direction. It is not as far as I want to go and probably as you want to go, but I think it is our best chance of getting where we need to be. So what we are going to do is raise that floor, which is now at $375, up to $475, and then it is going to move on up from there.

In addition, when you have the updates, if we are in those low-cost areas, we are going to get more in the updates than the areas that are higher than us. So it is going to narrow the gap and make it more likely that people are going to come in and offer these Medicare+Choice plans.

Now the one thing I want to say that hasn't been talked about here today is that I don't think a lot of folks understand the dynamics in rural areas like yours and mine. The real problem that is going on is with our providers because they are limited to the fee-for-service. We spend more money than we care to in Medicare, so we cut down and every year we ratchet down the percentage that we reimburse.

Many of these hospitals are 60 to 70 percent Medicare and Medicaid dependent. So they have no place to shift this. We keep screwing down the amount that we are going to reimburse the doctors and the hospitals to 55 percent—whatever it is—same thing in Medicaid. There is no way that these guys can stay in business. And that is the bottom line problem here.

So what we are trying to do is get another alternative to get the money out there so that these people can stay in business. And this is going to move us a long ways in the right direction.

Mr. WATKINS. Senator Breaux, can you share your feelings, and Mr. Thomas?

Mr. BREAUX. I think it is very clear that if you have a prescription drug program whereby you are subsidizing it as in our bill 25 percent across the board for all beneficiaries, plus you provide reinsurance funding for the companies for high-cost beneficiaries that they may have to cover, you are creating a package that is going to be very attractive in all parts of the country. As long as you have a backup so that when that doesn't work out you still have an agency that is going to do it, I think you have covered the problems of Rural America as well as urban areas.

Mr. WATKINS. In a lot of these, you only have one small drug store in the whole community. And sometimes the county. I don't know exactly how that is going to——

Mr. BREAUX. If you think about it, that small town with one drug store may have one or two Federal employees who benefit from the Federal Employees Health Benefit Insurance as well. They have insurance for drug coverage and they pay a copayment and they get their drugs at a very reasonable cost.

Mr. WATKINS. Good point.

Mr. THOMAS. I would tell the gentleman that if you go to the retail drug store and take a look at what you are paying there versus some of these mail-in drug provisions, you can actually wind up getting the same prescription at a much cheaper price and it arrives at your door. There is a revolution going on, both on the Internet—not everybody has computers to contact it—but certainly through mail-in provisions. People send their pictures away through the mail to get developed. There is no reason why you can't get prescriptions through the mail.

It is not as desirable a program as you would have, say, in an urban area. The key is that it is a program and it will be available.

The point that Collin Peterson made is a fundamental one. We have got to make sure that there is a cooperative effort in pro-

viding not just prescription drugs to rural areas, but basic health care. A hospital in an urban area that closes causes problems. A hospital that closes in a rural area collapses the core of the health care delivery structure.

So we are talking about continuing to monitor all those areas that need adjustment while we are looking at modernizations and while we are providing prescription drugs.

Just let me say that April 1 was a date we were promised to get a new funding mechanism for skilled nursing facilities. The Health Care Financing Administration missed that date. July 1 is the date that we were promised we were going to get a new funding mechanism for outpatient hospital payments. The Health Care Financing Administration is going to fail that date. At some point, somebody has to realize that when agreements are made and new structures need to go into place, that you have to meet that deal. The beneficiaries are the ones who suffer.

Mr. WATKINS. I would like to make one other point.

Chairman ARCHER. The gentleman's time has expired. He will have to make the point at a later time.

The Chair will alert members that it is the Chair's intention to recess the Committee at the conclusion of Mr. McDermott's inquiry and return with this panel to conclude this panel 1 hour later. We will recess for 1 hour for lunch at the conclusion of Mr. McDermott's inquiry.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I appreciate you having this hearing. I wish we would have a hearing when we had a bill in front of us.

As I listen to this debate today, we are asked to do two things at once. One is to deal with the drug benefit and the other is to reform Medicare. We are swallowing one pill in order to get the other pill.

I want to talk a little bit about the whole Medicare reform issue. I detest partisanship, so I am going to ask my question of Mr. Breaux and Mr. Thomas.

HMOs cost Medicare money because they enroll healthier than average people. The trustee's report for the year 2000 says that. You can quibble with them, but that is what it says. The OIG, the GAO, MedPAC, and HCFA all say that the HMO Program is not saving us money, but is losing Medicare money.

The theory has been in the reform of Medicare that if we got everybody into HMOs that somehow the private sector would figure out how to save money. But what I see in this bill is more money going into HMOs when the OIG, the GAO, MedPAC, and HCFA all say they are getting too much already.

Either those four Federal agencies don't know what they are doing, or mystically we are going to give this new Medicare Benefit Manager organization all the HMOs and the drug benefit and leave the fee-for-service system to wither on the vine in HCFA by separating them. Somehow that is going to make them better.

I would like to know how you figure you are going to make this thing work when—Mr. Peterson lives in an area like I do. I live in the most fiscally deficient area of the country. Minnesota and Oregon are with us. Everybody talks about rural areas. Never mind rural areas. Group Health of Washington is going to pull out of this

program in the urban areas if you don't give them more money in my area.

What mechanism have you built into this that deals with the disparities across this country? Is it somehow the employees of this agency who are not going to be Civil Service employees—you are going to hire them out of the insurance industry and pay them whatever you want—they will not be under Civil Service—how does that work to make it better?

Mr. THOMAS. I would tell the gentleman that the theory of getting them all into HMOs is only half the theory. The other half is that you then have competition between the HMOs, at the price at which they deliver the medical benefits.

What happened was that you only got half of it happening. That is, you created an HMO Program, but then the funding of that HMO Program or Medicare+Choice is administered prices—10,000 administered prices in 3,000 counties and where you have overpayment and over-utilization in some areas and underpayments in others. Or, for example, in your area, which is very efficient.

But unfortunately, it also has a direct competitor in another Federal Government program called the Department of Defense, which then has a profile offering that isn't examined and pulled out and then priced accordingly, again, because of the administrative structure. So what we propose is that you begin what the other half of the agreement was that has never been reached: Require competition.

Some of these plans are not going to like the other half of the solution. They like the idea that you give them more money where they need the money, especially in the lower area. This bill, on a bipartisan basis, also says to forget trying to get them to a demo on what a competitive model is. They are just going to be in a competitive environment. The Medicare Benefit Administration is going to negotiate prices, those below the national average.

You and I might want to say, let's take everything we are paying for Medicare+Choice and begin to divvy it up. As you well know, those who are now over-compensated are certainly not going to agree to that. They are not going to be part of the arrangement. So whether we like it or not, we are going to have to put more money out there than we should to allow those programs that have a fixed price that eventually will no longer be a handsome price until the competitive model reaches them and then they will negotiate as well.

We do provide negotiation and competition and assistance where you don't have the ability to negotiate and compromise. If one thing came out of the Medicare Commission, it was that the only way you are going to bend the growth curve 25 or 30 years out is to produced a Medicare that provides reasonable competition. Even if you have to spend a little money up front to get it started, it is in the long run the only way we are going to save the money.

Mr. MCDERMOTT. The only thing I would say is that the problem you face is the one you faced in 1997 when you made all the Balanced Budget amendments by yourself without having enough testimony. We wound up with the mess that we have today. You cannot do this again and ram it through here by Monday so that you

can have a press release next Friday, which is what we are doing. There is no question about it.

I rode on a plane from Seattle. I had 2,306 miles of hearing what is going on in the Senate where the same thing is being rammed through. I say to you——

Mr. BREAUX. Rammed through? When are we going to do that? [Laughter.]

Mr. MCDERMOTT. You watch and see. It will be rammed out of the House and you guys will do it next.

I don't want it to be partisan, but you need to take time to look at how this thing actually works and let us look at it and think about it. We are going to be out of here on Thursday night. We will not take a bill home to read, we will all come home on Father's Day on the planes to get back here on Monday not knowing whether or not we are going to have a piece of paper to look at.

Mr. THOMAS. No. My commitment to you will be that when you get on the plane on Thursday, if at all humanly possible—and I will say I will give it to you—you will have a bill to read. I will do that if at all humanly possible because I do want to meet that criticism. I think it is a legitimate one and I want to do it. I went to too many Majority Ways and Means meetings when the Democrats ran it where they passed paper out the day of the hearing. That is not what we are going to do. You will get it by Thursday when you get on the plane.

Chairman ARCHER. The gentleman's time has expired and the Committee will stand in recess until 1:35.

[Whereupon, at 12:37 p.m., the Committee was adjourned to reconvene at 1:42 p.m. the same day.]

Chairman ARCHER. The Committee will come to order.

The Chair invites any of the panelists who were part of the first panel who are present to have a seat at the witness table.

I assume that the Senators will not be returning and the Chair would suggest that the three of you consolidate and take seats at the center so that you are closer together in this bipartisan effort.

Congressman Thomas, why don't you sit in the middle and then we will put Congressman Allen on one side of you and Congresswoman Eshoo on the other.

The Chair recognizes Mrs. Thurman for inquiry.

Ms. THURMAN. Thank you, Mr. Chairman.

I am going to make a couple of statements, first based on some of the statements I have heard here today.

First of all, we talked a little bit about why we needed to be careful with having coverage that is better than any other plan because we would have other retirees' health care plans being eliminated or dropped.

I just want to say for the record we have already seen since 1994 a dramatic number of firms already dropping retirees' insurance, and people are still without a prescription drug benefit. In fact, about 25 percent fewer firms are now offering these plans.

I would also say that in my office recently a well-known retail company came in and said that because of the cost of prescription drugs they actually were going to have to reduce their benefits to their employees and their retirees because of prescription drug costs.

Mr. McCrery, one of the things that has concerned me and really deals with what Mr. Allen has brought fowward and I think needs to be reemphasized is that every Member of this Committee voted on the DOD authorization bill last week, which in fact does exactly what Mr. Allen's bill does. So if we say that we are for or not for price discrimination then we would have to suggest that we do that in every other program because we allow others to buy at the best price.

So I think what we are saying here is that it is OK for veterans and Medicaid and everybody else, but not for seniors.

To Mr. Peterson, one of the things that has really bothered me—we always talk about Miami, Florida—there is a lot more to Florida than just Miami. We have very similar situations as Minnesota and other places across the country. In fact, this past weekend, before this July 1st when Medicare+Choice programs have to let us know that they might be pulling out, we already have gotten the announcement that in two of my seven counties we are seeing them pull out.

The reason I bring that up is that you mention in your bill that you want to do a ceiling of $475.

Mr. PETERSON. That's a floor.

Ms. THURMAN. All right. A floor.

Well, let me just tell you about those counties where we have either lost or will potentially lose plans.

In Citrus County, they get $489 today. And they pulled out 2 years ago. Dixie County, $493. Hernando County—this will really be a shock—$543. Levy County, one that was below that floor, $466. Marion County, $459. Pasco County, $572. And Sumter County, $489.

Only one of those counties where they have either pulled out or are already pulling out of now are below that floor. So I don't know where we believe they are going to come in because of higher reimbursements.

And I quite frankly think that in the Medicare Program in general we have seen discrimination across this country. We already have, in the Medicare+Choice Program, a prescription drugs benefit. Right?

Mr. PETERSON. If you have enough money allocated to that county to be able to provide it.

Ms. THURMAN. No, because before that if you were in the Medicare+Choice before they pulled out, they had a prescription drug. That is why most enrollees went into it, correct?

Mr. PETERSON. Right. But in my area they didn't offer it at all.

Ms. THURMAN. So your folks have been discriminated against.

Mr. PETERSON. Right.

Ms. THURMAN. What I don't understand in the bill that you are talking about is, Why would we prop up Medicare+Choice, giving them more money, when they continually are pulling out of these counties, when they come to the point where they recognize they can't provide the services and exasperate the system that is already in place?

I don't know why we are doing that.

I will tell you, in talking to my seniors and what my seniors tell me, they want traditional Medicare. They don't want to be dis-

criminated against. They don't want beneficiaries and HMOs to be given special treatment with more benefits than they get. This is already what happens with Medicare+Choice. They don't want a two-tier system. They don't want to get their prescription drug benefits from the Medigap plans. They want a prescription drug benefit in Medicare as a part of their basic Medicare benefit and they want all beneficiaries to be treated fairly with the same Medicare benefits for all Medicare beneficiaries.

I don't see that happening under what you are proposing.

Mr. PETERSON. And I don't see it happening under the traditional system, either, because we only have so much money. And when the cost of Medicare goes up faster, what do we do? We reduce the fee-for-service reimbursement and then at my Medicare- and Medicaid-dependent hospitals, it doesn't work anymore. So the other system doesn't work, either.

I would like to put more money into this, but for whatever reason they made this decision, there is going to be $40 billion go into it. But I have more confidence that we are going to get there this way than we are going to get there in the all command and control HCFA——

Ms. THURMAN. But we have tried this system. That is what we have been under. That is what we have been doing.

Mr. PETERSON. Well, then, it is not working.

Ms. THURMAN. We had a two-tier system.

That is because we give the money to Medicare+Choice and you want to give it more.

Mr. PETERSON. Let me just make one more point.

Under this program, if they all pull out and if there are not two choices, then this new Medical Benefits Administration Board is going to have to, under this legislation, provide the drug benefit. So then they would get the traditional fee-for-service, plus a drug benefit under this bill.

Ms. THURMAN. Then let me go to Mr. Allen's issue because I think this is an important point.

Chairman ARCHER. The gentlelady will be accorded a small additional amount of time.

Ms. THURMAN. I appreciate that, Mr. Chairman.

Mr. Allen, in saying what they have just said, wouldn't it make sense that the one thing we have to do is to look at the best cost that we can get for government to buy these drugs? Is that what your piece of legislation does?

Mr. ALLEN. It is. And basically we want to do two things. We want a benefit that is affordable to seniors and a benefit that is affordable to the government, the taxpayer. That is why when we talk about any of these plans, we have to be focused on the cost containment, on getting some leverage over the pharmaceutical industry.

It is my belief that the more consolidated—that is, if Health and Human Services does the negotiating by itself for all 39 million beneficiaries, you are going to get a lower price than if you divide into regions and have PBMs. If you have multiple PBMs, you have less market power than if you have single PBMs.

So basically the fewer entities on the buying side, the more market power, which is why this debate—wherever you come out on it—the debate over the form of cost control is really very important.

Chairman ARCHER. The gentlelady's time has expired.

I think this has been a very productive discussion. It is not over yet because Mr. English and Mr. Doggett will still inquire. But I am constrained to interject at this time that it is not a zero sum game. You have many other countries that squeeze down the price of drugs so that if you want to sell them there, you have to sell them at a price that is less than they are sold in the United States.

What does that do to the prices for the consumers in the United States? That drives them up. It drives them up because it all has to fit within the final ultimate net return.

The more you drive down the price—even if it is domestic, it becomes comparable to the way that Canada and Switzerland and others have driven down the price of comparable drugs—and that forces up the price to everybody else. It doesn't come free of charge.

That is what we need to understand in the overall scheme of things. This is going to be a very difficult process to work through and come out with the right solution.

Mr. English?

Mr. ENGLISH. Thank you, Mr. Chairman.

I wanted first to recognize Mr. Peterson. I appreciate very much your being here. In listening to the last line of questioning, I am not sure you had an opportunity to fully amplify on your views and fully answer those questions.

Would you like time to do so now, sir?

Mr. PETERSON. Well, I think I pretty much got it answered. The problem is that—as I said briefly to the gentlelady from Florida—the fee-for-service system, the way we control costs and HCFA does it by setting these prices and continues to ratchet down—in my district, we have 70 to 80 percent Medicaid reimbursements in those hospitals. They are being put out of business.

At one time, before we got the $375 floor put in there, the average in my district was $293. At the same time, it was 700-some dollars in Miami. I can tell you that there isn't that much difference in what you pay doctors and what it costs. But the reality is that we are not going to take this money away from Miami or these other places, so we have to figure out some other way to get this thing equalized.

This bill starts to move us in the right direction.

Mr. ENGLISH. And I would point out to the gentleman—and I see the chairman of the Health Subcommittee is shaking his head. He is very well aware that in my district we have a situation similar to yours where we have seen not pull-outs but dramatic reductions in benefits. A lot of that is directly attributable to the fact that HCFA has arbitrarily decided in places like Northwestern Pennsylvania to reimburse the same procedures at a dramatically lower rate than in even Southwestern Pennsylvania.

So from county to county, I have an enormous disparity within my district and a significant difference in the availability of benefits under Medicare+Choice. That is not the fault of the insurance company—in this case, Blue Cross—as much as it is policy decisions being promulgated by bureaucrats right here in Washington.

Would the chairman of the Health Subcommittee amplify on that, if he chooses to?

Mr. THOMAS. Thank you very much.

I do think you heard a dramatic statement in the exchange between my friend from Maine and the gentlewoman from Florida: The concept that a government-controlled fixed price will ultimately produce a lower price than a competitive model.

That is being rejected around the world repeatedly. As a matter of fact, my colleague on my left—not always on issues, I might say—believes that competition is a key to controlling prices.

When you look at the government fixed price for Medicare, we have been told that if you could negotiate a lower price, you could actually get a cheaper price than the statutory price. But beyond that, it is not just the single price of the drug. The problem with many seniors is in taking the drug. It is the management of the drug. It is consulting with and appropriate delivery of the product. That is a package.

There are professionals who do that now. All of that should be part of the negotiations. Even disease management is part of the prescription drug program now—a very technical area—and they are doing it at reduced costs with intensive management. That is what should be part of the negotiations to determine who delivers the service, not just the price.

As most people know in the marketplace, the price isn't everything. It is the total package that is critical.

Mr. ENGLISH. A couple of quick questions for the chairman. Could you comment just very briefly on how his plan versus the President's plan would impact on PPS-exempt hospital and on the VA Prescription Program?

Mr. THOMAS. I would have to tell you that in those areas that we have worked at over the last several years, there is less than a dramatic impact because this is primarily for the modernizations in the prescription drugs. The area of the outpatient and the VA—although we are continuing to work—it seems as though that in the short run, even those who were pushing, for example, the Department of Defense Tri-Care Program to be advanced in terms of the drug ultimately see those Medicare-eligible senior as part of the overall program.

So this is not year one and the last year of continuing changes in Medicare. When we began in 1997 a cooperative effort with the administration—the administration did sign that bill—we knew we were going to have to make changes and we were going to have to make midcourse adjustments. We made a midcourse adjustment last year.

I will tell the gentleman, contained in the bipartisan legislation is a Medicare lock box to say that if CBO shows there are additional savings from Medicare in the general fund out of fiscal year 2000, all that money should be preserved for reinvestment back into Medicare. Those are areas we can focus on to assist areas we have talked about in terms of Pennsylvania hospitals in their ongoing concerns about delivering health care.

Chairman ARCHER. The gentleman's time has expired.

Mr. Doggett?

Mr. DOGGETT. Thank you, Mr. Chairman.

Mr. Allen, my questions really center on you. I know first of all that you must have been as happy as I was to learn that there is now an interesting bipartisanship in this Committee in addressing this issue. The only vote this Committee has ever taken on this issue previous to today was the vote that Ms. Thurman and I secured last September, in which we sought very much to have bipartisan support for addressing this problem of price discrimination against seniors that your proposal focuses on. Instead, we got a stonewall, a totally partisan opposition, a pretty straight vote that demonstrated Democrats wanted to end the price discrimination and Republicans did not want to act on that.

With reference to this spirit of bipartisanship, I understand how it is going to work. Mr. Peterson says he is not necessarily free to disclose all the details of this new, as of yet, unveiled plan today. We have a press release. If we are really fortunate, when we get on the plane to go away for the weekend, we will get a copy of the bill and then we will be asked to vote on this new proposal and shape any amendments dealing with the issues you have raised or others on Monday, the first day we get back.

So I guess that is a form of bipartisanship. It seems to focus principally on who can praise the proposal the most rather than who can focus on what impact, if any, it will have on our seniors.

Even though you don't have the details of this new Republican plan, isn't true—whether it is the Thomas Republican plan or the various Democratic plans that have been offered by a wide range of people here and in the Senate—that your approach represents the most conservative approach in terms of tax dollars? Isn't it the one that will cost the taxpayer the least amount of money of any of the proposals, whether they are called Republican, Democrat, or bipartisan?

Mr. ALLEN. That is certainly my opinion. I wouldn't expect everyone to come to the same conclusion. But it is certainly my opinion that basically when Mr. Thomas and others talk about the need for competition, I want to say, wait a minute. Let's talk about this in terms of market power. There are folks in this room who really understand what market power is all about. The pharmaceutical industry is by and large, when you look at different kinds of drugs, very much concentrated. What the industry wants is as many buyers as possible. That way any individual buyer will have the least amount of market power.

Aetna, Cigna, United—all the health care plans—try to negotiate lower rates for their beneficiaries. In my opinion, Medicare should simply do the same for its beneficiaries. If we do that systematically, we will have the lowest possible prices around the country. And I can imagine doing that with 15 or so regions, but by and large the more different buyers you have, the less market power the buyers will have.

Mr. DOGGETT. I think you have seen this morning's Congress Daily that has an advertisement from the pharmaceutical industry suggesting that with private insurance seniors cen get lower prices somewhere near 40 percent. Is there anything to prevent them from simply lowering their prices by 40 percent for uninsured seniors without any bill of any type?

Mr. ALLEN. No, there is nothing. It is a fairly amazing advertisement because it basically says that private drug insurance lowers prices 39 percent and that 12 million senior Americans now have no prescription drug insurance coverage and therefore pay full price because they don't have the market clout that comes with a plan. That is part of what we are saying.

Let me say one other thing that I think is important. Referring back to the chairman's point a while ago, this industry earns 18.6 percent return on revenues, according to the latest figures. As Merrill Lynch and other security analysts have shown, if you have either my plan or a benefit, they will sell many more drugs in this country. It is not a case of simply dropping prices in one country and forcing them up in another.

By and large, this is a case where if they cut prices or you have a benefit, then their market will expand dramatically because so many seniors are not taking their prescription drugs right now.

Mr. DOGGETT. As Mr. Matsui pointed out before our Republican colleagues convened this bipartisan hearing, they convened a focus group that warned that "Republicans aren't doing anything to help seniors," and their number one message to attack Democrats seemed to have you in the bull's eye. It said that the way to attack Democrats is to say, "It is politicians in Washington setting drug prices."

Isn't that what your plan does?

Mr. ALLEN. My plan provides what we do for military retirees now, what we do through the Medicaid Agency, and for veterans. It simply allows the negotiation of negotiated lower prices and essentially what happens in the private sector.

Mr. DOGGETT. The military retiree plan is the one you refer to in your testimony that the House just voted overwhelmingly to approve. It is a new plan that has not existed previously that is going to take the same approach that you want to provide for all uninsured seniors, and apply it to all military retirees.

Mr. ALLEN. Over 65, that is correct.

Chairman ARCHER. The gentleman's time has expired.

Mr. DOGGETT. Thank you.

Chairman ARCHER. The Chair is prepared to close out the inquiry of this panel in deference to them and their schedules as well as deference to Nancy Ann DeParle, who has waited a long time.

The Chair will recognize Mr. Neal, who has not inquired, and the Chair will then recognize Mr. McDermott simply for one question, which he tells me will receive a yes or no answer. That remains to be seen.

Mr. Neal?

Mr. NEAL. Thank you, Mr. Chairman.

Just a quick question for Bill Thomas, and the other panelists may wish to comment as well. I followed some press accounts of how you intend to deal with the whole question of recovering some of the investment that we make on behalf of taxpayers on some of the miracle drugs. It is an issue that, while on the periphery, it is still out there. Maybe you could inform us as to your intentions.

Mr. THOMAS. I will tell the gentleman someone who is very interested in that is Senator Ron Wyden. He has legislation and others do as well.

In working on this side with the Democrats over a year and a half, we examined a number of areas that we thought about adding to the bill. We came to the conclusion that as we put this together we are going to try to keep it a core Medicare modernization in prescription drugs.

The difficulty with the number of areas mentioned—although it may in fact be a worthwhile pursuit—it opens up then, through the Commerce Committee jurisdiction, the entire Federal Drug Act and that is not a direction, given the rules of the House, that some folks wanted to go. I am talking with those people who have an interest in providing legislation, even as an amendment to this one that we can sit down and talk with the Rules Committee, where something like that could be made in order if someone—and the will of the House can be determined on that.

The response I get back is that the taxpayers invest in a number of areas, such as defense and others, and they don't get a return on their investment there. I think maybe it is something we need to look, in a broad-based way, about. Although certainly government's job is to sponsor research and development in a broad number of science areas, and there is a societal benefit that accrues, but if an individual is going to receive significant personal benefit from it, then there might be a way for the government to piggyback onto that and get our fair share back, but only if there is somebody who gets a single individual significant benefit out of the broad-based taxpayer dollars.

So there is an area I think we can continue to work. But rather than to put it in this bill, which has to go through both Ways and Means and Commerce, opening up jurisdiction like the entire FDA was a sobering thought for a number of people, especially those on the Commerce Committee, who are part of the bipartisan coalition. They suggested that we not do it in the fundamental bill, but as an amendment it is something that could be looked at.

Mr. CARDIN. If I could respond, Mr. Neal, I think Medicare beneficiaries have overpaid for a lot of the costs—whether it be research, whether it be academic, health care costs, training of doctors—there has been an unwillingness to look at a more general way to cover these costs, and it has made it more difficult for us to move forward with benefits for our seniors.

One of the key differences—this has been a very useful discussion, but I think one of the key differences that we have on the approach Mr. Thomas has taken and the approach Mr. Stark has taken, is that Mr. Stark's approach puts drug coverage as a defined benefit within the Medicare system itself. That means every senior will get it.

Yes, we hope there will be choice, that private insurance will be involved. In 1997, we passed Medicare+Choice to give the seniors—we thought—more choice, but private insurance didn't want to take advantage of that.

One of the dangers, if you don't put prescription drug coverage in the defined benefit package, is that the private market may or may not do what we think they will do. They may offer it in different ways. But if you have it as a defined benefit in the core benefit structure of Medicare, then you know the seniors will have at

least the fall-back of fee-for-service and competition will give other options to our seniors.

So I think the point you raise about recouping the investment cost is a very important one, and we should make sure that our seniors aren't going to overpay for the benefits they are receiving, which would mean that they won't be able to receive other benefits or expanded benefits because of the costs we are providing for the Medicare system itself.

Mr. THOMAS. Perhaps this defined benefit argument may be more a semantical one than a substantive one. I want to sit down with Ben and go over it.

When I was listening to what people are arguing as a defined benefit, it was the specific parameters of the dollar amounts of the program, and I really don't look at it that way. I look at it as the substance of what it is that is being offered, such as the preventive care and other aspects. It may in fact be a semantical one and we may have a defined benefit in this bill, once I understand exactly what the gentleman from Maryland means.

Mr. NEAL. I think we need to talk that out, but I think many of us want to start with the concept of putting it in the core benefit, the defined benefit, of Medicare and then make it available for big delivery through fee-for-service or private plans. You start with getting the private sector——

Mr. THOMAS. But I would only say that the core benefit are specific health care factors, not dollar amounts. You are not talking about prescription drugs as dollar amounts. That is not what I look at as a defined benefit. I look at it as the programmatic aspect, which is the way traditional Medicare is. That is why I think it may be more a semantic problem than a substantive one.

Chairman ARCHER. The gentleman's time has expired.

The Chair now recognizes Mr. McDermott for a short question that will receive a yes or no answer.

Mr. McDermott?

Mr. MCDERMOTT. Let me see if I can do it.

Mr. Thomas——

Mr. THOMAS. Me? Yes or no?

[Laughter.]

Mr. MCDERMOTT. He said a short question for me, too.

When you were designing this benefit, did you expect the same administrative cost in your benefit that is in a Medigap policy? And is that built into the cost of the premium?

Chairman ARCHER. The gentleman is also free to answer "I don't know."

Mr. THOMAS. I do know. That is the problem. A yes or no is not a sufficient answer.

This is so fundamentally different than Medigap. There are administrative costs and CBO is pricing it out, but it is nothing like Medigap in terms of the administrative costs because it covers an entirely different structure, in large part administered by newer entities that didn't really exist in the current form they exist when Medigap was put into law.

But I am still going to try to get it to you on Thursday.

Chairman ARCHER. Thank you.

The Chair extends personal compliments to every member of this panel. It has been very, very helpful, I believe, to the consideration of this issue. We are very grateful to all of you.

Thank you very much.

Chairman ARCHER. The next panel will be Hon. Nancy Ann DeParle and Gary Claxton.

Ms. DeParle, my apologies for your having to wait so long. It just seems to be a part of this process, that is, the U.S. House of Representatives. But we are very happy to have you before us today and we will be most pleased to receive your testimony.

You may proceed.

Ms. DEPARLE. Thank you, Mr. Chairman.

Chairman ARCHER. I think everybody knows that you are the Administrator of HCFA, so I don't think you need to mention that again. Welcome.

STATEMENT OF HON. NANCY-ANN DEPARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION; ACCOMPANIED BY: GARY CLAXTON, DEPUTY ASSISTANT SECRETARY FOR HEALTH POLICY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. DEPARLE. Thank you.

I do think this morning has been constructive and I have learned a lot from listening to the dialog.

We appreciate your holding this hearing to discuss the Medicare prescription drug coverage problem. The Health Subcommittee's hearing on this subject last month was very constructive and we welcome the opportunity your hearing provides today to further our bipartisan dialog.

With me this afternoon is HHS Deputy Assistant Secretary Gary Claxton, who has worked extensively on analyzing and designing the President's prescription drug proposal and also analyzing the other proposals that are out there.

The Administration is encouraged by the growing commitment to address this issue, the need of Medicare beneficiaries for a prescription drug benefit. We want to continue working with you to enact legislation that meets the key principles that President Clinton has laid out for a Medicare drug benefit.

The drug benefit should be voluntary and accessible to all beneficiaries. It should be affordable to beneficiaries and to the Medicare Program. It should be a competitive benefit and it should have efficient and effective administration. It should ensure access to needed medications. It should encourage high-quality care. And it should be consistent with broader reform.

Mr. Chairman, we have said many times that we are flexible on the details of how a Medicare drug benefit is provided as long as the design meets these key principles.

I was listening closely to the members of the panel who presented earlier. I listened especially closely to Mr. Thomas in talking about the plan he has been working on.

I do see some commonalities. It does appear that he has tried to meet some of the President's principles and that he has made some changes at least from earlier versions of the plan that I have heard. But as I think everyone has emphasized this morning, I

haven't seen the details yet—we haven't seen the details yet—so it is very difficult to say whether or not this plan meets the tests that I set out to make sure that this is really a guaranteed Medicare prescription drug benefit.

We do have some concerns, based on what we have heard so far, about whether this benefit would really be affordable and accessible for all beneficiaries. Most of our comments and concerns really relate to this.

We continue to be concerned about the extent to which the plan that Mr. Thomas described this morning relies on participation by private insurers who have made clear many times that stand-alone drug policies aren't feasible. Even if some insurers do offer coverage—I imagine some will—they would likely come in and out of the market, they would move to marketable areas, and I suspect they would significantly modify their benefit design from year to year based on the prior year's experience.

We have seen this before and it has not been a good thing for beneficiaries. I should just mention here that there appears to be a lot of confusion about how exactly Medicare+Choice reimbursement rates are set, so I want to just take a minute to describe that for this Committee.

This Committee set the rates in law in the Balanced Budget Act a couple of years ago. They are based on historical rates, the 1997 rates, which are based on historical fee-for-service volume and intensity, which is why you have such differences around the country. The practice of medicine has differed around the country in the Medicare Program, the number of procedures people get and the types of doctor visits, and so forth. The rate of increase was also set by statute. It is not something that bureaucrats or that I set at HCFA. It is set by statute and is the higher of three different rates, but there is a guaranteed annual increase of 2 percent in that rate.

But as I said, what we have seen—and everyone here knows it, many of you are experiencing this first-hand—is pull-outs, a lot of movement by Medicare+Choice plans, a lot of uncertainty, and a lot of instability. We are concerned that a plan that relies heavily on private insurers would create the same kinds of concerns again in the Medicare prescription drug benefit.

I heard Mr. Thomas say that the government will be there in every area if plans don't come in to provide a Medicare prescription drug benefit. I am eager to see the details of that and what that would really mean. My concern in hearing about it, from a health policy perspective, is, What exactly would that mean for risk selection? If the government is going to be left in some areas, does that mean that plans wouldn't come to many areas of the country, leaving the government there, which would have to charge higher premiums? That results in what my actuaries tell me is sort of a "death spiral" for such a program if it is a drug-only program.

So I guess, Mr. Chairman, I would just say that this dialog has been helpful in learning some of the details, but there many, many more things we need to discuss. There are certain difficulties inherent in trying to base a program on drug-only insurance plans. I think you will hear more about that today.

We continue to believe that the benefit must be integrated into the Medicare Program, that it should be like physicians. Physicians are covered under Medicare, hospital visits are covered. It should be just like that. We should provide drug coverage to Medicare beneficiaries the same way that virtually all private insurers do, by contracting directly with pharmacy benefit managers in each region of the country. This will ensure that all beneficiaries have access and that Medicare gets the best prices through benefit managers who will negotiate on behalf of beneficiaries.

This raises another concern that we have with the plan Mr. Thomas discussed this morning, which is that, as he described it, it does not provide direct premium subsidies to individuals with incomes above $12,600 a year. As I understand it, it does provide a direct subsidy to very low income people. For everyone else, it relies on indirect subsidies to lower premiums. As I understand it, the subsidies are paid to the insurance companies and the proposition is that that will lower premiums for everyone.

I think what is not clear is whether this amount of subsidy will really ensure that affordable coverage is available to all, or would be equally affordable in all regions of the country. I heard this morning a sincere debate about how to do that. I believe that everyone wants to do that. My question is whether this plan really does do that.

We have other questions, Mr. Chairman, that are outlined in my written testimony. We look forward to discussing them with you. I think the most important question that we all have to keep in mind is, How well does this plan, does the President's plan—does whatever plan you have in front of you—really meet the needs of Medicare beneficiaries, the 39 million Americans who are depending on us to do something here? We have to keep that first and foremost.

And while critical concerns remain, I hope that the time and energy and commitment I have seen here this morning means that we are turning a corner in our efforts to work together to enact a Medicare drug benefit. We all agree that it is desperately needed. I hope we are nearing a workable consensus on the broader outlines of how the benefit should be structured.

Now, Mr. Chairman, we need to get into the important deeper details of how to make sure that the benefit can succeed. I think we can meet these challenges if we continue the constructive approach we have taken so far and I look forward to continuing to work with you as we enter the next phase in this critical debate.

Thank you.

[The prepared statement follows.]

Statement of Nancy-Ann DeParle, Administrator, Health Care Financing Administration

Chairman Archer, Congressman Rangel, distinguished Committee members, thank you for holding this hearing to discuss Medicare prescription drug coverage. Your Health Subcommittee hearing on this issue last month was highly constructive, and we welcome the opportunity this hearing provides to further our bipartisan dialogue. We are encouraged by the growing commitment embodied in the new House Republican proposal to address this issue. We want to continue working with you to enact legislation that meets the principles President Clinton laid out earlier this year.

Background

As we know, pharmaceuticals are as essential to modern medicine today as hospital care was when Medicare was created. Lack of prescription drug coverage among senior citizens today is similar to the lack of hospital coverage among senior citizens when Medicare was created. Three out of five beneficiaries lack dependable coverage. Only half of beneficiaries have year-round coverage, and one third have no drug coverage at all.

Those without coverage must pay for essential medicines fully out of their own pockets, and are forced to pay full retail prices because they do not get the generous discounts offered to insurers and other large purchasers. The result is that many go without the medicines they need to keep them healthy, out of the hospital, and living longer lives.

Drug coverage is not just a problem for the poor. More than half of beneficiaries who lack coverage have incomes above 150 percent of the federal poverty level. Millions more have insurance that is expensive, insufficient, or highly unreliable. Even those with most types of coverage find it costs more and covers less. Copayments, deductibles, and premiums are up.

And coverage is often disappearing altogether as former employers drop retiree coverage, Medigap is becoming less available and more expensive, and managed care plans have severely limited their benefits. Clearly all beneficiaries need access to an affordable prescription drug coverage option.

KEY PRINCIPLES

The President has identified key principles that a Medicare drug benefit must meet, and we are willing to support proposals that meet these principles. It should be:

• **Voluntary and accessible to all beneficiaries. Medicare beneficiaries in both managed care and the traditional program should be assured of an affordable drug option. Since access is a problem for beneficiaries of all incomes, ages, and geographic areas, we must not limit a Medicare benefit to a targeted group. At the same time, those fortunate enough to have good retiree drug benefits should have the option to keep them.**

• **Affordable to beneficiaries and the program.** We must ensure that premiums are affordable enough so that all beneficiaries participate. Otherwise, primarily those with high drug costs would enroll and the benefit would become unstable and unaffordable. And beneficiaries must have meaningful protection against excessive out-of-pocket costs.

• **Competitive and have efficient administration.** Medicare should adopt the best management approaches used by the private sector. Beneficiaries should have the benefit of market-oriented negotiations.

• **Ensuring access to needed medications and encouraging high-quality care.** Beneficiaries should have a defined benefit that assures access to all medically necessary prescription drugs. They must have the assurance of minimum quality standards, including protections against medication errors.

• Consistent with broader reform. The drug benefit should be consistent with a larger plan to strengthen and modernize Medicare.

THE PRESIDENT'S PLAN

The President has proposed a comprehensive Medicare reform plan that meets these principles. It includes a voluntary, affordable, accessible, competitive, efficient, quality drug benefit that will be available to all beneficiaries. The President's plan dedicates over half of the on-budget surplus to Medicare and extends the life of the Medicare Trust Fund to at least 2030. It also improves access to preventive benefits, enhances competition and use of private sector purchasing tools, helps the uninsured near retirement age buy into Medicare, and strengthens program management and accountability.

The President's drug benefit proposal makes coverage available to all beneficiaries. The hallmark of the Medicare program since its inception has been its social insurance role. Everyone, regardless of income or health status, gets the same basic package of benefits. This is a significant factor in the unwavering support for the program from the American public and must be preserved. All workers pay taxes to support the Medicare program and therefore all beneficiaries should have access to a new drug benefit.

A universal benefit also helps ensure that enrollment is not dominated by those with high drug costs (adverse selection), which would make the benefit unaffordable and unsustainable. And, as I described earlier, lack of drug coverage is not a low-income problem beneficiaries of all incomes face barriers.

The benefit is completely voluntary. If beneficiaries have what they think is better coverage, they can keep it. And the President's plan includes assistance for employers offering retiree coverage that is at least as good as the Medicare benefit to encourage them to offer and maintain that coverage. This will help to minimize disruptions in parts of the market that are working effectively, and it is a good deal for beneficiaries, employers, and the Medicare program. We expect that most beneficiaries will choose this new drug option because of its attractiveness, affordability, and stability.

For beneficiaries who choose to participate, Medicare will pay half of the monthly premium, with beneficiaries paying an estimated $26 per month for the base benefit in 2003. The independent HCFA Actuary has concluded that premium assistance below 50 percent would result in adverse selection and thus an unaffordable and unsustainable benefit.

Premiums will be collected like Medicare Part B premiums, as a deduction from Social Security checks for most beneficiaries who choose to participate. Low-income beneficiaries would receive special assistance. States may elect to place those who now receive drug coverage through Medicaid into the Medicare drug program instead, with Medicaid paying premiums and cost sharing as for other Medicare benefits.

We would expand Medicaid eligibility so that all beneficiaries with incomes up to 135 percent of poverty would receive full assistance for their drug premiums and cost sharing. Beneficiaries with incomes between 135 and 150 percent of poverty would pay reduced premiums on a sliding scale, based on their income. The Federal government will fully fund States' Medicaid costs for the beneficiaries between 100 and 150 percent of poverty.

Under the President's plan, Medicare will pay half the cost of each prescription, with no deductible. The benefit will cover up to $2,000 of prescription drugs when coverage begins in 2003, and increase to $5,000 by 2009, with 50 percent beneficiary coinsurance. After that, the dollar amount of the benefit cap will increase each year to keep up with inflation. For beneficiaries with higher drug costs, they will continue to receive the discounted prices negotiated by the private benefit managers after they exceed the coverage cap. To help beneficiaries with the highest drug costs, we are setting aside a reserve of $35 billion over the next 10 years, with funding beginning in 2006.

Benefit managers, such as pharmacy benefit manager firms and other eligible companies, will administer the prescription drug benefit for beneficiaries in the traditional Medicare program.

These entities will bid competitively for regional contracts to provide the service, and we will review and periodically re-compete those contracts to ensure that there is healthy competition. The drug benefit managers—not the government—will negotiate discounted rates with drug manufacturers, similar to standard practice in the private sector.

We want to give beneficiaries a fair price that the market can provide without taking any steps toward a statutory fee schedule or price controls. The drug benefit managers will have to meet access and quality standards, such as implementing aggressive drug utilization review and patient counseling programs. And their contracts with the government will include incentives to keep costs and utilization low while assuring a fairly negotiated contractual relationship with participating pharmacists.

Similar to the best private health plans in the nation, virtually all therapeutic classes of drugs will be covered. Each drug benefit manager will be allowed to establish a formulary, or list of covered drugs. They will have to cover off-formulary drugs when a physician certifies that the specific drug is medically necessary. Coverage for the handful of drugs that are now covered by Medicare Part B will continue under current rules, but they also may be covered under the new drug benefit once the Part B coverage is exhausted.

The President's plan also strengthens and stabilizes the Medicare+Choice program. Today, most Medicare+Choice plans offer prescription drug coverage using the excess from payments intended to cover basic Medicare benefits. Under the President's proposal, Medicare+Choice plans in all markets will be paid explicitly for providing a drug benefit in addition to the payment they receive for current Medicare benefits. Plans will no longer have to depend on what the rate is in a given area to determine whether they can offer a benefit or how generous it can be. This will eliminate the extreme regional variation in Medicare+Choice drug coverage, in which only 23 percent of rural beneficiaries with access to Medicare+Choice have access to prescription drug coverage, compared to 86 percent of urban beneficiaries.

And beneficiaries will not lose their drug coverage if a plan withdraws from their area, or if they choose to leave a plan, because they will also be able to get drug

coverage in the traditional Medicare program. We estimate that plans will receive $54 billion over 10 years to pay for the costs of drug coverage.

Beneficiaries will have access to an optional drug benefit through either traditional Medicare or Medicare managed care plans. Those with retiree coverage can keep it and employers would be given new financial incentives to encourage the retention of these plans.

MEETING KEY PRINCIPLES

We are flexible on the details of how a Medicare drug benefit is provided, but the design must ensure that we meet the President's key principles of a benefit that is voluntary, affordable, competitive and efficient. We have reviewed draft descriptions of the plan, but we have not seen the details. Based on this review, we believe the new Republican plan marks important progress. However, we believe it does not meet the President's test of a meaningful benefit that is affordable and accessible for all beneficiaries. Key among our concerns are the apparent lack of an individual premium subsidy for all beneficiaries, an inadequate level of support, and reliance on insurers who are unlikely to participate.

Will prescription drug coverage be available?

The Republican plan appears to rely extensively on participation by private insurers who have made clear that stand-alone drug policies are not feasible. Subsidizing private insurers instead of establishing a reliable Medicare benefit means that outpatient prescription drugs would not be part of the Medicare benefits package like doctor or hospital care. Beneficiary premiums would pay for expensive, private Medigap plans whose administrative costs are on average more than 10 times higher than Medicare's, according to National Association of Insurance Commissioners statistics, rather than an affordable Medicare option. Furthermore, Medigap plans have little experience negotiating with drug manufacturers and relying on numerous plans does not pool the purchasing power of seniors; both elements are needed to keep the benefit affordable.

Building on the private Medigap insurance market would be especially difficult in sparsely populated rural areas, where risk pools are smaller and seniors are more likely to have higher costs, as a report released by the President today shows. There also is no certainty or stability in the drug coverage options in the Republican proposal. Even if some insurers do offer coverage, they would likely come in and out of the market, move to profitable areas, and significantly modify benefit design from year to year based on prior year's experience. This would result in the same pullouts and uncertainty we see in managed care today.

The drafts of the new proposal suggest reliance on a "fall back" mechanism, in which the government would ensure availability everywhere. This seems to acknowledge the weakness of the drug-only insurance plans. We continue to believe that Medicare should provide drug coverage the same way that virtually all private insurers do—by contracting directly with pharmacy benefit managers in each region of the country. This will ensure that all beneficiaries have access and that the pharmacy benefit managers can negotiate the best prices.

Is drug coverage affordable to all beneficiaries?

The Republican plan does not provide direct premium subsidies to individuals with incomes above $12,600 a year. Instead, it appears to rely on indirect subsidies of 25 to 30 percent to lower premiums. It is unclear that this amount of subsidy will ensure that affordable coverage is available to all or would be equally affordable in all regions of the country.

There are several additional areas where we have questions about the new Republican plan. These include:

• *Is it a defined benefit?* The Republican plan appears to allow insurers to offer an unspecified "standard" benefit, or an actuarial equivalent benefit. Only the stop-loss amount is specified, and insurers would set deductibles and copays.

This could lead to beneficiary confusion and benefit packages designed for "cherry-picking" of low-cost, healthy enrollees, with insurers offering no deductible, low copays, and a low benefit cap that leaves a large gap before the stop-loss kicks in. This would be a step backwards from the Medigap reforms of the early 1990s that standardized benefits so plans compete on price and quality rather than consumer confusion.

• *Does the plan assure access to needed medications?* The Republican plan appears to require insurers to cover only all "major" therapeutic classes of drugs. Depending on how that is defined, and the degree to which each insurance company is permitted to define it, some seniors could be left without the medications they need. It also appears to require a beneficiary to go through a formal appeals process to

get coverage of off-formulary drugs the physician deems to be medically necessary, which could limit access. Furthermore, the Republican's multi-insurer approach breaks up the pooled purchasing power of seniors, forcing insurers to reduce costs through restrictive formularies and limited pharmacy choice.

• *Will the plan increase access to coverage for rural beneficiaries?* The Republican plan appears to rely on additional assistance for Medicare+Choice plans as a means of bringing those plans into rural areas where, because of sparse health care service delivery structures, managed care has often had difficulty thriving. It is not clear this will work.

• *Will the proposed approach to remove international drug pricing disparities work?* We agree that Americans, particularly those who now lack prescription drug coverage, should not disproportionately subsidize drug development. However, it is not clear that having the U.S. Trade Representative negotiate to address drug price controls in other nations will result in fairer prices here at home. This proposal could simply result in higher prices abroad without having an impact on the high prices American consumers now pay.

• *Will the plan result in more efficient Medicare administration?* We understand that the Republican plan would create a new Medicare Oversight and Management Administration (MOMA) to administer the drug benefit and the Medicare+Choice program. It appears to be adding a new layer of bureaucracy since many MOMA activities would duplicate those that HCFA would also need to continue, such as beneficiary education, resulting in duplication and ignoring HCFA's expertise.

CONCLUSION

We may be turning a corner in our efforts to secure the Medicare drug benefit that we all agree is needed. We are nearing a workable consensus on the broader outlines of how the benefit should be structured. Critical concerns about providing an affordable, accessible, meaningful benefit and relying on private insurers remain. But we are beginning to get into the all-important, deeper details of how to make sure the benefit can succeed. While a great deal of work remains, momentum is now with us. The challenges before us can be met if we continue the constructive approach that we have, together, taken to date. And I look forward to continuing to work with you as we enter the next phase on this critical issue.

# # #

Chairman ARCHER. Thank you, Ms. DeParle. And again, thank you for your patience in waiting to present your testimony. We are delighted to receive it. Hopefully the spirit of cooperation will permeate the structure of our procedures as we move forward.

If I may, I would like to ask you just a few questions.

Have you prepared the President's program in statutory language so that we can be able to put it side by side with whatever other program we might be looking at?

Ms. DEPARLE. Yes, sir, we have. I believe it was submitted in February or March.

Mr. CLAXTON. March.

Ms. DEPARLE. It was submitted to the Congress.

Chairman ARCHER. Has it been in any way revised or changed since then? Or is it intact as it was submitted in March?

Ms. DEPARLE. It hasn't been revised, sir, but we have said that we want to work with the Congress to add to our program a catastrophic benefit to protect beneficiaries who have really high drug expenditures. We intend to do that. That is an outline.

Chairman ARCHER. That is the item that Ms. Eshoo mentioned in the stop-loss concept?

Ms. DEPARLE. Yes, sir.

Chairman ARCHER. Has there been a CBO analysis revenue assessment of the plan that you sent up in March?

Ms. DEPARLE. I know that our actuaries have looked it. I haven't seen a CBO analysis. I will ask Mr. Claxton is he is aware.

Mr. CLAXTON. I believe that they estimated the overall plan, but they didn't estimate the catastrophic component because——

Chairman ARCHER. I understand. That is something that still needs to be worked out.

Mr. CLAXTON. Right.

Chairman ARCHER. Okay.

Ms. DEPARLE. I am remembering now that at the last hearing in front of your Health Subcommittee CBO testified and they did say it was going to be around $159 billion over 10 years.

Chairman ARCHER. Do you remember a 5-year number?

Ms. DEPARLE. No, sir, I don't. I am sure I can supply that for the Committee.

Mr. CLAXTON. It is $38 billion over 5 years.

Chairman ARCHER. OK, $38 billion and $159 billion.

I apologize. I was not present at that hearing, so some of my questions may be a tiny bit redundant, but I will try to keep it very brief.

Chairman Thomas is talking about a $40 billion expenditure, so we are in the same ballpark as far as dollars are concerned to the taxpayer. Is that fair to say? Over a 5-year period.

Ms. DEPARLE. I know that is what the Budget Resolution says, and I know that is what he is trying to design. I believe that ours would be more expensive with the catastrophic.

Mr. CLAXTON. In the President's proposal, we propose a catastrophic plan to start in 2006, consistent with the amount of money that was available in the budget. If our catastrophic program started earlier, it would cost more than $38 billion.

Chairman ARCHER. I see.

Based on your own analysis, could you give us some idea of what the first 5 years would be if you put the catastrophic or stop-loss in effect at inception?

Mr. CLAXTON. We can certainly provide that for the Committee. We don't have it right now.

[The information follows:]

Ms. DeParle: If we take the basic prescription drug benefit, as proposed by the President in his February budget, and move the effective date one year earlier, to 2002, and add an out-of-pocket limit of $4,000 indexed to growth in the drug component of the CPI, the net federal budget impact of the entire drug would be $79 billion for FY 2001–2005, and $253 billion for FY 2001–2010. This policy and this estimate assume a beneficiary premium contribution for only the base benefit, so the out-of-pocket protection would be fully financed by the federal government.

Ms. DEPARLE. If we take the basic prscription drug benefit, as proposed by the President in his February budget, and move the effective date one eyar earlier, to 2002, and add an out-of-pocket limit of $4,000 indexed to growth in the drug component of the CPI, the net federal budget impact of the entire drug benefit would be $79 billion for FY 2001–2005, and $253 billion for FY 2001–2010. This policy and this estimate assume a beneficiary premium contribution for only the base benefit, so the out-of-pocket protection would be fully financed by the federal government.

Chairman ARCHER. We still do not have the statutory language of the——

Ms. DEPARLE. No, sir, I do not. I am sure I could supply that for the Committee.

Mr. CLAXTON. It is $38 billion over 5 years.

Chairman ARCHER. That was $38 billion. Okay, $38 billion and $159 billion. All right. I apologize, I was not present at that hearing, so some of my questions might be a tiny bit redundant. But I will try to keep it very brief.

Chairman Thomas is talking about a $40 billion expenditure. So we are in the same ballpark as far as dollars to the taxpayers are concerned over a 5 year period. Is that fair to say?

Ms. DEPARLE. Well, I know that is what the budget resolution says, and I know that is what he is trying to design. I believe actually that ours would be more expensive with the catastrophic.

Mr. CLAXTON. In the President's proposal we propose a catastrophic plan to start in 2006, consistent with the amount of money that was available in the budget. If our catastrophic program started earlier, it would cost more than $38 billion.

Chairman ARCHER. I see. All right.

Could you, based on your own analysis, give us some idea of what the first 5 years would be if you put the catastrophic or stop loss in effect at inception?

Mr. CLAXTON. We can certainly provide that for the Committee; we do not have that right now.

[The information was not received at the time of printing.]

Chairman ARCHER. OK. We still do not have the statutory language of the Thomas-Peterson bill. Hopefully, we will have it by either very late tonight or before the close of business tomorrow. Sometimes I have to add "hopefully" the way things work here, and sometimes the difficulty in scoring takes a longer period of time.

In the end, the Committee needs to be concerned about the total dollar cost to the taxpayers as well as the total affordability to the individual beneficiary. Moving to the beneficiary side of it, what does your proposal require from the standpoint of the beneficiary who elects to go into this program? As I understand it, both would be a matter of choice; people could either elect it or not elect it. So can you tell me, Ms. Eshoo mentioned $44 a month, is that the figure that you also would ascribe to, without the stop loss or catastrophic?

Ms. DEPARLE. The premium starts off in the first year, sir, at around $26 I think, and then it rises as the cap on the benefit goes up to $5,000. So the premium goes up to about $50 four or 5 years out.

Chairman ARCHER. All right. Is it fair to say that when fully implemented with the $5,000 coverage it would be $50 a month?

Ms. DEPARLE. That is what our estimates are, yes, sir.

Chairman ARCHER. OK.

Ms. DEPARLE. And there is also coinsurance and we expect beneficiaries to pay 50 percent.

Chairman ARCHER. Yes. Yes. Okay. So with the $26 premium in the first year, what coverage would that provide?

Ms. DEPARLE. It would provide coverage up to $2,000 for drug spending from the first prescription that a beneficiary had covered, and then the beneficiaries would also get the benefit of the lower

prices that the pharmacy benefit managers could negotiate if they had cost above the $2,000.

Chairman ARCHER. OK. All right. So you would get, in effect, $1,000 of coverage for a $26 a month premium, as it were? Because there is a 50 percent copay and you have up to $2,000, $1,000 has got to be paid by the beneficiary?

Ms. DEPARLE. Yes, sir.

Chairman ARCHER. OK. As of this time, it is not possible to compare that to the Thomas-Peterson plan because we do not know precisely what those numbers are going to be. We will have those when we mark up next week.

I think that defines to some degree what we are talking about. Do you have any view as to what participation would be required by the beneficiary for the catastrophic or stop loss benefit?

Ms. DEPARLE. No, sir, we do not. That has been something that has been criticized quite a lot that we have not put a plan on the table. But we were really sincere in wanting to work with the Congress to look at the contours of that.

Chairman ARCHER. No, that is fine.

Ms. DEPARLE. There are a number of different ways to do it; there are three or four already out here. We are open to discussing it.

Chairman ARCHER. Do you anticipate that there would be an additional premium for that stop loss coverage of some number, whatever it might be?

Ms. DEPARLE. We have not made a decision about that yet. That is one way of doing it is to ask for an additional premium. Another way is to have a lower benefit but not ask for an additional premium. So we are still open to discussing it.

Chairman ARCHER. All right. The various plans that are being proposed by different people have some differences between plans other than the Thomas-Peterson and the administration's proposal, but, apparently, all of them provide for choice and election rather than being a mandatory program that you would have to participate in if you were a Medicare beneficiary. Is there a concern that the Committee should have about adverse election?

Ms. DEPARLE. Yes, sir. In any of these plans, that is something that you need to look at.

Chairman ARCHER. And what would be the way that we could address that?

Ms. DEPARLE. Well, an important way to address it is, according to the actuaries that we have consulted as well as, frankly, private insurance plans that provide these kinds of benefits, is we have to make sure that the subsidy that we offer to beneficiaries is adequate to encourage most of them to participate. Again, it is voluntary. But just as we have done with part B of Medicare, we want to have this subsidy be adequate to encourage them to participate. Why do we want to do that? Because if we do not do that, then the ones who participate are the ones who are really the sickest and that just creates a very difficult risk pool, you are familiar with those principles, and then adverse selection on top of that.

So I think that is a key parameter to keep in mind as we evaluate the various plans.

Chairman ARCHER. I am not surprised. I am always realizing that the ingenuity of the American people in this great land of the free is such that people are going to decide what is in their own best interests. And if I am a retired citizen and covered by Medicare, and I am one of the 20 percent that does not pay anything on drugs, I am basically healthy and I do not see that I am going to have a major drug obligation, I am not going to get into this. Whether the premium is $26 a month or whether it is $50 a month, I am going to say, gee, that is a lot of money for me over a year's time, why should I do that. And I am one of the very ones that you need to get in to get away from the adverse selection. So what do we do about that? I am not just identifying this as a problem for your program. I think it is potentially a problem for all of them.

Ms. DEPARLE. I think we have to look at the experience of other programs. You could make the same argument for that with Medicare part B. There are people who have very low costs during the year. So what entices them to come in? I think what it is with this population, in particular, while they may not be sick right now, they know that there may be a time when they are sick and that they will need that. It is the whole principle of insurance. It seems to have worked OK with Medicare part B and I believe that it will work.

I see your point, but I think that is why the actuaries and the private insurance experts that we have talked to say it is important to make sure that the government's contribution is substantial enough. Also, there are rules about when you can come in and you have to make an election at the beginning and that sort of thing.

Chairman ARCHER. OK. Thank you very much.

Mr. Rangel.

Mr. RANGEL. Thank you.

There are some Republicans that make the accusation that the President and Democrats really do not want to resolve this problem but would prefer to have it as an election year issue. I do not know how they can think that since we do not have the slightest clue as to what finally the Republicans, with their newly found bipartisan Democrats, are going to come up with and say this is the solution. I, for one, really believe that older folks do not want a Democrat solution or a Clinton solution or a Republican solution, they want relief.

It seems as though the so-called Democrat solution is to treat prescription drugs as we treat medical care and to say people are entitled to it and do it through the Medicare Program. Others believe that we can do away with Medicare and have HMOs take over this type of responsibility and subsidize the private institution. If we wanted to shatter this myth that this was some political conspiracy, has Mr. Thomas and his bipartisan group approached the administration to see whether or not they could come up with a bipartisan bill with the President's support?

Ms. DEPARLE. I have not been approached, Mr. Rangel.

Mr. RANGEL. Would you know whether or not there has been an attempt by the Republican leadership to get the President on board this piece of legislation that Mr. Thomas is putting together?

Ms. DEPARLE. I think I would. I have said, and I said this at the hearing that the Subcommittee had last month, we are open to sitting down and working with whatever group up here wants to work with us to try to enact a real Medicare prescription drug benefit. We are open to sitting down whenever and wherever they want to talk. But as far as I am aware, that has not happened yet.

Mr. RANGEL. Some Republicans think that they have to fight both Democrats on the Committee as well as the President. Is Mr. Stark's Subcommittee recommendations that far apart from the President's recommendations?

Ms. DEPARLE. The Subcommittee recommendations being——

Mr. RANGEL. The Democratic Caucus.

Ms. DEPARLE. From my understanding of it, the differences are fairly minor. They have to do with implementation dates and with things at the catastrophic——

Mr. RANGEL. So the Republicans would not have to worry that they are dealing with a two-headed monster. It would be a one-headed monster, the differences, right? It is possible that the Democratic Caucus and the White House could find a meeting of the minds.

Ms. DEPARLE. Yes, sir, I think it is.

Mr. RANGEL. You are talking a lot about bipartisanship, and the Republicans are talking a lot about markup. How do you think that is going to work?

Ms. DEPARLE. Well, at some point we are all going to have to get together and put all of these issues on the table and work through each one of them. The devil, I think Ms. Johnson is the one who said it this morning, but the devil is in the details. There are a lot of commonalities but we have yet to really roll up our sleeves and do the hard work. Maybe the markup starts that.

Mr. RANGEL. I yield to Ms. Johnson to see how we are going to do all this rolling up the sleeves between now and Monday.

Mrs. JOHNSON [Presiding]. Welcome, Administrator DeParle. It is my understanding that in the material that you gave us on the President's summary that your estimates of cost assume 95 percent participation.

Ms. DEPARLE. Yes, that is right. The actuaries believe that the levels we are talking about would ensure that level of participation.

Mrs. JOHNSON. OK. I just wanted to clarify that. I agree with your earlier statement that to get participation the plan has to be rich enough to attract it. By my calculations, to pay the $24 monthly premium and the 50 percent copayment, you would have to pay $1,288 for a $1,000 benefit. In other words, you would have to need to spend $1,388 to get a $1,000 benefit. About 80 percent of the seniors have less than $1,388 expenditures. So they would not be motivated under your plan to choose this plan if they were part of the 80 percent that did not have that benefit.

Now the same criticism could be made of every other plan on the table. One of the reasons why the group that I worked with was so intent on catastrophic is because we thought the catastrophic benefit would give peace of mind to the people whose drug costs were only $500, $600, $700 but they were paying actually more than that between the copays and the premiums for the commensurate benefit.

I asked the Congressional Budget Office, because I think this is very important to get on the record in this discussion, I asked the Congressional Budget Office what would be the cost of catastrophic if it were mandatory. So this is the lowest possible cost. Nobody is proposing mandatory anything. But I wanted to see if you spread the cost of catastrophic across every single senior in America what would it cost. And this is what it would cost: In the first year, for a $6,000 threshold, it would cost $21.60, and by 2010, it would cost $38.70, almost $40, almost as much as your 10 year premium would rise to $44. So, if we put catastrophic in there at $6,000, you would have a $44 premium and a $40 catastrophic premium.

Now I understand you are expecting some government cost-sharing. I just want to put on the table how really expensive this is.

Mr. STARK. Would the gentlelady yield for just a moment on the numbers.

Mrs. JOHNSON. Yes.

Mr. STARK. The President's plan for $1,288 would give you $2,000 worth of benefits, not $1,000.

Mrs. JOHNSON. Well, see, but $1,000 of that is your own money, and $1,000 is the government's money. So you spend $1,000 of your money on copayments, $288 on premiums, and for that you get a $1,000 benefit.

We will have to discuss this later because I do not want to get stuck down in the conceptual——

Mr. STARK. OK. But you are wrong.

Mrs. JOHNSON. I think I am right. In other words, if you have to pay for first dollar, if your prescription is $50, you pay $25, they pay $25. So from the very beginning you are paying half over and above your premium. So before you benefit by $1,000 worth, you have spent $1,000. So that is why I say it that way.

Ms. DEPARLE. If that is what your level of spending is.

Mrs. JOHNSON. If it is lower, you spend less.

Ms. DEPARLE. That is right.

Mrs. JOHNSON. And I figured that out all along the continuum. The fact is that you do not get to the point where there is much of a pay-off for low drug users because of the premium and the copays. You see, the premiums offset the copays until you get up. Anyway, I do not want to spend too much time.

Ms. DEPARLE. I think what we are arguing about, as you point out, this is an issue, an aspect that every single plan should be analyzed with respect to. And arguing about the principle of insurance, you being from Connecticut, I am sure you know better than most that——

Mrs. JOHNSON. But remember, those of us who were here during catastrophic, and I voted against repeal, the concern of the seniors was that they had to pay something for something that they did not want to buy because they did not believe they needed it.

In my estimation, the only real lure of this program is not going to be the 50–50 up to $2,000. It is going to be the catastrophic coverage. But you have to combine them, and all the plans do. I just want to put on the record that combining them is very expensive. And if you are not going to take it out of premium, you are going to have to take it out of general funds. At a certain point, we are going to have to engage in the fact that in 10 years I believe it is

Medicare is going to be 25 percent of all Federal spending, and that is without Social Security or the other senior benefit programs including Medicaid and long-term care costs. So that is an important problem.

Then I also wanted to ask you why you made the decision to have your plan adjust for inflation rather than for the drug inflation costs, rises in drugs. When you talk to seniors they will tell you right away Social Security adjusts for inflation, my rent goes up more; Social Security adjusts for inflation, Medicare goes up more. So if we do not adjust this program to begin with for drug costs, we will not give our seniors what we are telling them that we will give them. Now if we do that, of course it will be more expensive and the premiums will go up more rapidly. But I think we have to be honest about that. I think one of the problems we are going to have to tackle together is this issue of inflation versus drug costs. If you want to comment on that, you are welcome to do so.

Ms. DEPARLE. I think you are asking a lot of very good questions. As I have said many times, we are open to sitting down and talking to you about details like the ones you are raising.

I do think though a lot of what you have raised goes to the very heart of the principle of insurance and whether you believe that people want insurance or not. My understanding from all the actuaries and experts we have talked to is that a system like the one we have proposed can work. Maybe others can work as well, but ours can work.

I disagree just a little bit with Mr. Thomas on that in the sense that when I go out and talk to our beneficiaries, yes, they do want catastrophic coverage, but they also think they really need help right now and they want help with covering the basic cost of drug coverage.

Mrs. JOHNSON. I hear what you are saying about that. But a 95 percent assumption behind your cost estimates is, to me, really misleading because there are so many people out there, every State employee has far better coverage than this. And the idea that they are going to give up their better coverage, and there is no chance they are going to lose it, that a lot of public employees will give up their better coverage to make that rate 95 percent, especially without catastrophic, is not common sense.

Now if we add catastrophic, that may help. But we are never going to get that shift from the private sector to the public sector, nor do we want it. So cost estimates based on 95 percent I think are really unrealistic. But these are the details we will have to consider.

Ms. DEPARLE. And let me be clear, too, Ms. Johnson, we did not tell someone, the actuaries to assume 95 percent. What we asked them to do was to help us design something that would achieve almost universal participation by beneficiaries. They believe, based on the parameters of the plan that we have come up with, that it would do that.

Mr. Thomas is talking to analysts from CBO. I am sure they have views of this. There are lots of experts out there who have views about this. That is one of the details that you alluded to that we have got to sit down and start talking about.

Mrs. JOHNSON. I would really like to talk to your estimators about why they would estimate 95 percent when we know that two-thirds of seniors already have some kind of drug coverage and one-third have very good drug coverage. I think we need to have them come talk to the Committee about why they would do this.

I do not want to take more time just because I have the Chair, but I do want to put on the record that I also strongly disagree, and I cannot emphasize this enough, and I want to emphasize it in public, I strongly disagree with your funding mechanisms. Personally, to assume that PBA extenders would provide $39 billion more over 10 years when, frankly, I am doing the best I can to defer most of the PBA requirements, because we are already saving more than was anticipated when we passed those provisions in PBA, so since we are saving more from Medicare than we anticipated, I certainly am not going to support a 15 percent cut in home health benefits, I certainly am not going to support a continued decline in uncompensated care for hospitals and some of the other factors.

So not only do I think that your PBA extenders estimate is not going to materialize, but I think your estimate of $8 billion over 10 years through a competitive bidding for Medicare+Choice when the choice plans are crumbling because they are so underfunded, and the same with $25 billion over 10 years for reduced Medicare spending in a number of other areas, most of them competitive bidding and stuff, I cannot agree that the money you say is going to materialize is going to materialize. So I think both the cost of adding catastrophic coverage and the real funding have to be looked at because it is from those assumptions that you draw your $24 premium.

Ms. DEPARLE. We will be happy to sit down with you and talk about the details.

Mrs. JOHNSON. Thank you.

Mr. Thomas.

Mr. THOMAS. Thank you, Madam Chairman. I apologize for running out and trying to get something to eat, but I was listening to the discussion that was going on.

It is true, one of the more difficult parameters in trying to create a product is to not give too much away to get people to participate, but also give enough away to encourage people to participate. The Medicare part B, seventy-five cents on the dollar attracts 97 percent of the people. I guess we could go to ninety cents on the dollar and get that other 3 percent. It is a question of what you do in return.

Partially I think, although I am somewhat concerned about the way their actuaries determined the 95 percent take-up rate on the President's plan, it is in part A function of how much you subsidize, and they subsidize fifty cents on the dollar up to $2,000. It is kind of like questionnaires today, it is how you ask the question. If you asked the question, would you like to have protection there when the costs exceed your ability to pay? They will say, yes. Do you want a program that covers your first dollar expense? They will say, yes. So as you get in, you have got to be very careful what you ask, how you ask it, and what you are looking for.

But if, in fact, CBO scores, for example, the bipartisan proposal near 90 percent, we are in the ballpark of shaping a program that most people think is one that is worthy of participating in. I think we should set that aside temporarily.

I do think that we should look at the record because the Medicare Commission built a program which was an insurance program. The President offered initially in his budget a program that really did not have catastrophic. It was brought to the catastrophic table by our argument that it should really be an insurance program. It did not kick in until 2006 and with not enough details for CBO to deal with. And then the Democrats, in adding to the President's program, in that recent Rose Garden ceremony, offered catastrophic today similar to ours, but did not have details and said the Secretary would trigger it. There was no cost associated with it. So it was not really a realistic plan.

I just want to underscore that from the very beginning we started with the concept of building an insurance plan, not so much for what seniors even think they need today or over the next three to 5 years. It is going to take a major push on everybody's part to get this program in place and you are not going to be able to go in and fiddle with it periodically on fundamentals like whether or not it is an insurance program or a prepaid plan. We just thought, looking down the road over the next five to 10 years and the costs that seniors would be facing, it would be worth it to get in place a program which was a true insurance program.

I also heard Mr. Rangel's question of you. I would ask you, Ms. DeParle, did you consult with the Chairman of the House Subcommittee when you were making up your Administration's budget that you were going to present to us?

Ms. DEPARLE. No, sir.

Mr. THOMAS. You did not?

Ms. DEPARLE. No.

Mr. THOMAS. So some of the things that are executive branch involvement I did not get to participate in, and some of the things that are Legislative Branch involvement you did not get to participate in. Frankly, down the road we both wind up participating. So the idea that in building this bipartisan plan we did not consult with you and, therefore, somehow it is tainted is once again an argument that is presented with absolutely no substance or usefulness in advancing the fact that the first panel had six Democrats and one Republican and five of the six Democrats sounded awfully similar in the idea that they wanted competition and that they wanted the administrative structure outside of HCFA. As a matter of fact, the gentleman from Maryland, as he indicated, was not so disturbed at what it was, but that it did not have a defined benefit. I actually think that is resolved as well, and we are going to sit down and work on it.

The only way we are going to move forward is the way we moved forward in 1997, looking at what we have in common, stressing the commonalities, and building on that. To the degree that the questions continue to visit what somebody said behind closed doors, slipped to somebody in a leaked procedure, to the degree that you use pejorative terms, as you define them to be pejorative, to try to slow down the ability to come together in a relatively short time

to resolve our mutual problem means you do not want it resolved, no matter how much you say you are for it.

There is a bipartisan proposal. It will continue to build. Frankly, the judgement of the bipartisan proposal will not be the vote in this Committee. Everybody knows how people get along in this Committee. The proof of the bipartisanness of the measure will be the vote off the floor of the House. I think you will find that when this measure reaches the floor there will be an overwhelming bipartisan vote. My only hope is that it will be sufficiently bipartisan to be able to carry over to the Senate and wash those folks up on the beach of reality as well so that we can possibly move forward with the Senate proposal, get the conference, invite the administration to fully participate, as we did in 1997, and surprise everyone by doing something for seniors, and that is modernizing Medicare and passing prescription drugs before we go to the election. That would be a pleasant memory that I would love to provide the President of his Administration, and, frankly, we should not have beneficiaries wait 1 day longer than necessary to provide this very useful service.

Thank you, Madam Chairman.

Mrs. JOHNSON. I agree with that. And it would be a very pleasant memory.

Ms. DEPARLE. It would be a nice memory for me, and I would like to work together with you on it.

Mrs. JOHNSON. Mr. Stark.

Mr. STARK. Thank you, Madam Chairman.

I love this discussion on bipartisanship. We Democrats provided a couple hundred votes to help the Republicans carry the Patient Bill of Rights on the floor. That has done us precious little good in the Senate. We cannot get them to move to carry our bill at all. So we are getting tired of getting all these Democratic votes to help the Republicans carry their bill only to have it defeated in the Senate.

A couple of other housekeeping things here. I would just like to go over—I took my shoes and socks off to do this math, Madam Chair, and I know we are not taking the standardized math test here—but as I understand the President's bill, and far be it from me to be defending the President, but if a person were to receive $2,000 worth of drugs from the pharmacy, they would pay $1,000 in cash as a copay and their premium, if we assume it is $24, would be $288. Thus, for an outlay of $1,288 of cash they would receive $2,000 in pharmaceuticals. If they go in and buy a $2,000 prescription, one prescription let's say, they would pay $1,000 copay, right, so they get $2,000 worth of drugs for $1,000 copay.

Mr. THOMAS. Would the gentleman yield because I think you are on to something. Would the gentleman yield briefly on that point because I want to agree with him. Would the gentleman yield just very briefly?

Mr. STARK. OK. I know you do.

Mr. THOMAS. You do not want me to agree with you?

Mr. STARK. I do. It is so obvious that——

Mr. THOMAS. If the partnership pays out $2,288, the government covers $722 of it——

Mr. STARK. I would reclaim my time.

Nancy, I have some questions about managed care and HMOs and that sort of thing and drugs. Not knowing what is going to happen, I heard Mr. "Bipartisan" Peterson this morning suggest that we are going to save managed care in his rural district, there are no HMOs in his district I believe, I know there are no HMOs in North Dakota, and can you estimate for me how much you would have to pay per person to get an HMO to go into Fargo or Oaks, North Dakota. Any idea?

Ms. DEPARLE. I am trying to see if I can remember what the——

Mr. STARK. The population of Oaks is 3,000.

Ms. DEPARLE. Well, what the county payments would be in that area already. They are probably whatever the floor is.

Mr. STARK. Maybe $300 or $400. Is there any amount of money under which an HMO could survive?

Ms. DEPARLE. Well, it depends on a lot of factors. It depends on a network. It depends on whether there are people in those areas who want to go in. There is one statistic though that is at least chastening when you look at this, which is that around 26 million of the 39 million Medicare beneficiaries right now have access to a managed care plan.

Mr. STARK. And do not join.

Ms. DEPARLE. Well, around 7 million have. But that means there are others who have not, even though, in my estimation——

Mr. STARK. Why would anybody in their right mind join a managed care plan, and HMO except to get a pharmaceutical benefit? You restrict your access to physicians, whereas under Medicare fee-for-service you can go to any physician you want. You restrict your access to hospitals. You are denied certain covered services if the managed care plan decides to withhold benefits from you. Why would you join a managed care plan except to get the drug benefit?

Ms. DEPARLE. You might join one if you looked at the price of Medigap, which, as you referred to earlier this morning, is very expensive and the drug benefit you get is sometimes less than the amount you are paying. If your doctor is in the managed care plan and they offer prescription drugs which you cannot get through Medicare.

Mr. STARK. I said if you did not get prescription drugs why would you do it. You can still go to that doctor, can't you?

Ms. DEPARLE. Yes, sir. But in the past, some of the managed care plans have had lower coinsurance.

Mr. STARK. Or none.

Ms. DEPARLE. Or none. In fact, they have had quite generous premium arrangements. So there have in some cases been benefits. But I have been surprised actually that even where they are available many beneficiaries have not joined. I do not know what the reason is for that. But that is one of the things that makes me a little nervous about depending too heavily on that part of the marketplace.

Mr. STARK. Then why would we give in managed care plans more money if we are already, as we suspect, overpaying them? In other words, we pay more to the managed care plans compared to paying for those same people in fee-for-service Medicare. So why would we give more money to managed care plans instead of just letting every Medicare beneficiary have a drug benefit, which would there-

by save the managed care plans money, would it not? In other words, if we provide a drug benefit to every Medicare beneficiary, the managed care plans or the HMOs who now provide a drug benefit save money, do they not?

Ms. DEPARLE. Well, they save money or they make money, depending on how you look at it. Under the President's plan, $54 billion of the $160 billion in our plan would be going to managed care plans to cover drug benefits. The problem right now is that they need to cover drug benefits, as you suggest, to be competitive. I have talked to a number of the chief executive officers of these plans and they tell me that to provide the kind of benefit that Medicare beneficiaries want they have to be able to provide prescription drugs and some of those other things. But under the Medicare+Choice law, we are not supposed to be reimbursing them to provide prescription drugs.

The solution is we need a prescription drug benefit for all Medicare beneficiaries. I guess I would have to say, Mr. Stark, that I think there are some areas of the country where we may never have managed care plans. That may be OK as long as beneficiaries have access to a decent, affordable prescription drug benefit. And that is why I would like to work together with this Committee to get that done.

Mr. STARK. Thank you.

Mrs. JOHNSON. Mr. Levin.

Mr. LEVIN. Let me just say for those of us who are left here in terms of bipartisanship, and Mr. Thomas, your comment, I think as I look back at the legislation that has been within the jurisdiction of our Committee, if there is not bipartisanship on the Committee, the legislation does not become law. So if there really is no effort to forge a bipartisan kind of package here, there may be some Democratic votes on the floor, a minority, but it will not become law. Essentially, what we will be doing is positioning ourselves and I think doing a lot of posturing.

So I think the test is not the floor, whether there will be a minority, and probably a small minority, of Democratic votes, but whether between now and Monday there can be the kind of dialog among Democrats and Republicans here on the Committee and with the administration that we can proceed other than essentially on a partisan basis here in the Committee.

Therefore, I want to ask you, Ms. DeParle, because we have gotten lost in a lot of speculative details, we do not have a bill in front of us, just to lay out so that everybody understands the challenge between now and Monday, there has been some reference to common ground, there us if you would in as simple terms as you can what you think are the basic differences on key items between what is being proposed by Mr. Thomas and is embodied in the President's proposal. In your testimony I think you lay these out in terms of whether it is a defined benefit, in terms of whether it will cover needed medications. But try to spell out the four or five major differences that you think need to be faced between now and Monday, or whenever we are going to get our heads together, if we do.

Ms. DEPARLE. I will try. The President's plan makes a prescription drug benefit available to all Medicare beneficiaries. It is an in-

tegral part of the Medicare Program. Medicare beneficiaries would be entitled to coverage for prescription drugs just the way they are now for physician services or hospital services.

Mr. LEVIN. A higher copay.

Ms. DEPARLE. Yes.

Mr. LEVIN. But it is otherwise basically the same as other services.

Ms. DEPARLE. Yes, sir. They pay a separate premium for it, and there is a higher copay. There is a 50 percent copay. But it is part of the Medicare Program and it is an entitlement.

We provide it through pharmacy benefit managers who would negotiate——

Mr. LEVIN. But as you understand the Republican plan, it is not?

Ms. DEPARLE. I think that we do not know, sir. I heard Mr. Thomas say this morning that it is an entitlement. From what I had seen earlier it was not clear to me that it was an entitlement, except perhaps for the low income beneficiaries. There is not a direct subsidy for all beneficiaries. I did not see the word "entitlement." I think the word "entitled" is in there once. I have not seen the details. I do not know whether it is a guaranteed benefit or whether it is just available in certain areas of the country. I heard him say today that he intends to have Medicare, a government plan be a fall-back in every area. But I just do not know the details. So that is my question, is it really a benefit for all Medicare beneficiaries, or is it just in the areas where it is available through a private insurance plan.

Mr. LEVIN. And whether it is affordable for everybody.

Ms. DEPARLE. Yes, sir. That would be the second question. Again, I do not want to speculate because I saw a five or ten page summary a week ago. Some of the details are different than what I heard Mr. Thomas and Mr. Peterson say today. So I do not want to speculate on it. But we do have a question about whether it is affordable. Again, it may be affordable to people who have one of those private insurance plans available. Is it also affordable to people who do not have such a plan available? We want this to be universally affordable.

There is also a question about the extent to which all of the details can vary among the plans. That goes to both accessibility and affordability and, to the stability of this marketplace. It sounds like what they are talking about would offer lots of different permutations of a Medicare plan, which might sound good in theory, but what I hear when I talk to beneficiaries is they want something that is stable. They want to know how much they will be paying, they want to know what their premiums are going to be from year to year. They do not want something that is going to be that uncertain. So that I think is another key difference between the plans.

I also have a question about whether or not the administration of the new plan is going to ensure access to needed medications. Again, I do not want to speculate, but an earlier draft I saw of a plan did talk about requiring coverage only of major therapeutic classes of drugs. It is not clear what that means.

Mr. THOMAS. Will the gentleman yield briefly?

Mr. LEVIN. Sure.

Mr. THOMAS. You keep referring to some five or ten page document. Who did it come from? Is it the Senate plan, Breaux-Frist plan?

Ms. DEPARLE. I was told it was the House Republican plan, which must be an earlier version because——

Mr. THOMAS. Who told you it was the House Republican plan?

Ms. DEPARLE. It was called the Medicare Prescription Drug and Modernization Act. We got it from someone on the Hill.

Mr. THOMAS. The question I thought was to compare the one plan to the other plan. We just consumed 3 hours saying it is an entitlement, it is universal, it is going to be provided through a public-private arrangement, but if it is not that way then it is going to be provided by the public. So I appreciate the gentleman giving me the time. But I did not spend 3 hours reviewing the particulars not to hope somebody would not get the fact that the bipartisan bill is not a Republican bill. You keep referring to documents you say were given to you that is a Republican plan. The bipartisan plan that Mr. Peterson and I talked about today is not the Republican plan. And is there any surprise that, in fact, what you keep referring to is not in our plan.

I thank the gentleman for the time.

Mr. LEVIN. Let me just suggest, Mr. Thomas, and then I will finish, as I said earlier, I think a plan that comes before this Committee is a Republican plan if there is not a real effort to involve Democrats on the Ways and Means Committee.

Ms. DEPARLE. And I am not trying to engage in any speculation, Mr. Thomas. But Chairman Archer said this morning that we had already had a hearing on the President's plan and he hoped we would not spend time on that. That is what I am most prepared to talk about. I am trying to do the best I can with the materials that have been provided. I apologize if they are not correct. And I have said many times that I listened very carefully to what you said and I heard you say that you intend this to be universal. I am not saying that it is not. I am not making that affirmative statement. I am saying that I do not know based on what I have seen.

Mr. LEVIN. Thank you.

Mrs. JOHNSON. Thank you.

I would like to just bring this back to what are some of the most difficult issues. I think there is a lot of similarity in terms of entitlement and universality and copays and things like that. But I would like to bring it back to this issue of negotiated price and whether or not——

Mr. MCDERMOTT. Madam Chair, when are the rest of us going to get a chance to ask questions?

Mrs. JOHNSON. You will come next. I have had two Democrats, I am going to one Republican, then I will have two Democrats because my Republicans left.

Mr. MCDERMOTT. So you are taking all the Republican shots.

Mrs. JOHNSON. There are issues that we want to get on the record that we have not been able to get on the record.

I want to understand better how using a single pharmaceutical benefit manager to negotiate price we would avoid price-setting. It seems to me it becomes then synonymous, that with only one negotiator, then that is effectively a private sector agent of the govern-

ment setting the price. Then another aspect of that question is that price and formulary in the private world are usually very intimately related. In the President's plan, is the pharmaceutical manager allowed to use formularies, is he allowed to use utilization review, and so on and so forth to control costs? Or is it just negotiated price?

Ms. DEPARLE. First of all, we are not using just one pharmacy benefit manager. We are proposing to use a number of different ones, as many as want to compete in this system, but we do it by regions. There will one per region. The reason for that is we want them to be able to negotiate the best price for a number of beneficiaries in a particular region. We do not want it to be different in Connecticut than it is the adjoining States.

Mrs. JOHNSON. Is there any precedent for one in a region being able to get the best price if there is nobody to compete against them in that region?

Ms. DEPARLE. I think they do that right now with a lot of private insurers. Most private insurers who use a PBM use one for different areas of the country. So, yes, I believe that there is.

Second, your question was whether or not we would allow formularies. The answer to that is, yes. However, beneficiaries would have the ability, if the physician felt that a drug that was not on the formulary was what in his or her medical judgement was what the beneficiary needed, they would have the ability to get that drug.

Mrs. JOHNSON. So the model is one pharmaceutical benefits manager and whatever formulary that pharmaceutical benefits manager had negotiated. I think one of the differences between the two plans is if there is more than one plan and more than one pharmaceutical benefit manager, there will be a variety of choices in terms of do you want to trade off a lower premium and higher benefits for more restrictive benefit manager. And having come from a part of the country where particularly psychiatric drugs have been managed for a while, I can tell you there is a big difference in managers, some I would not mind having and others I would mind an awful lot. So I do not necessarily want the government to negotiate with the lowest price person.

Ms. DEPARLE. It would not just be on price, Ms. Johnson. We would look at quality and service as well. It would not just be who has the lowest price.

But one concern I have is raised by your earlier question, actually. If you have pharmacy benefit managers competing the way you described, and this is I think something in Mr. Thomas' bill as well, where there are lots of different types of prescription drug benefit packages out there, that may sound good in the abstract, but you introduce a considerable risk selection into the process then with plans being able to cherry-pick and offer to the healthier beneficiaries. Then that starts a spiral again where you do not have insurance anymore at a certain point. What you have is something where the less well-off and the sicker beneficiaries will not be able to afford it.

So somehow we have to strike a balance between offering the kind of choice that you are talking about and making sure that we

have a plan that is stable and financially able to provide the benefits.

Mrs. JOHNSON. I look forward to working on that with you. I do think also it would be a terrible error of public policy to put this kind of benefit out and not in any way incentivize people to participate in these disease management protocols that cut other costs of Medicare.

Ms. DEPARLE. We have talked about that and I want to work with you on it.

Mrs. JOHNSON. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chair.

I always try to think about this as if I were a senior citizen, and I am finding it easier to think about that. I want to understand the President's plan. Would it be the anticipation if you were running the plan under HCFA that you would deduct the premium from my Social Security check?

Ms. DEPARLE. Yes, sir.

Mr. MCDERMOTT. So everybody would have paid into the plan, and then you would distribute the money out to whatever plan benefit manager my mother or any senior in that area, if they had *x* clients, they would get *x* number of dollars for giving that benefit. Is that right?

Ms. DEPARLE. Yes, sir.

Mr. MCDERMOTT. On an equal basis across the country? Or would it be like gasoline prices, where in the middle West they are at $2.20 a gallon and in Seattle it is $1.63 a gallon. How would you——

Ms. DEPARLE. It would be an equal basis throughout the country. The pharmacy benefit managers are not at-risk in this, so they just would receive a payment for each beneficiary and they would manage on their behalf.

Mr. MCDERMOTT. So Merck, Medico, or somebody like we have that is located in New Jersey or Massachusetts, wherever they are, they would get all the money to cover what was going on with Seattle, or Minneapolis, or Provo, Utah, right?

Ms. DEPARLE. Right.

Mr. CLAXTON. Yes, sir. They would make disbursements from Medicare for the benefits, yes.

Mr. MCDERMOTT. Since we have to imagine what the Republican plan is all about, apparently they are going to set up another administration, and if I am a senior citizen and I decide to go into Medicare+Choice and I am in an HMO, also my drug money is going to go into that same new administration. You will not have any of it over at HCFA because they are going to administer the whole drug benefit from this new administration. Is that how you understand it?

Ms. DEPARLE. In an earlier draft, there was the MAMA administration, yes.

Mr. MCDERMOTT. What happens when they close my HMO, as they did last year for 700,000 people, and I now have to go over into the fee-for-service program over at HCFA? You, because you are now going to pay my bills. This administration is not going to pay them anymore. I am going to move over here. So now my money is split; some money goes to the benefit manager, some of

it goes to HCFA. Is that right? Is that too simple-minded? I am trying to think like my mom thinks.

Ms. DEPARLE. Well, I am not sure I followed the last movement. You said that your HMO pulled out.

Mr. MCDERMOTT. Yes, it pulled out and so I have got to go to the fee-for-service plan.

Ms. DEPARLE. Right.

Mr. MCDERMOTT. So now I am covered under HCFA for my medical care. But my drug money stays over in managed——

Ms. DEPARLE. Oh, I see what you are saying. I believe if you are in an HMO, under Mr. Thomas' plan, the HMO would get all the dollars including the prescription drug dollars. But the idea would be they would get the Medicare capitation payment which would include prescription drug money for you. If your plan pulls out, then you would go back to fee-for-service. I see what you are saying. I do not have enough details to know whether the prescription drug money for you would be administered by MAMA, or the Medicare benefits administration that he talked about today, or whether that would go back to HCFA.

Mr. CLAXTON. There is not really enough detail. We have been told there will be a fall back Medicare plan in areas where there is not private plans available. But we do not know how it would be administered; whether we would charge a premium, whether the premium would vary by area, or any of those details. We have to wait for the plan I think.

Mr. MCDERMOTT. It seems to me though that there is a third option. Unless you are going to require every HMO to provide pharmaceutical benefits, there will be some people over here at an HMO who are not covered for their pharmaceutical benefits under their HMO and will get it from your fall back position. Is that correct?

Ms. DEPARLE. Under our plan, a prescription drug benefit would be part of the basic Medicare benefit package and all HMOs would be required to provide it. I have been assuming that Mr. Thomas' plan also made that part of the Medicare benefit package and that HMOs would be required to provide it. Maybe I am wrong about that.

Mr. MCDERMOTT. So it is a question of whether or not under the HMO they are required to give a pharmaceutical benefit or not. Is that correct? That has to be written into the law.

Ms. DEPARLE. Yes, I think that is an issue that I am not clear on.

Mr. MCDERMOTT. So if I join an HMO, I am going to get pharmaceutical benefits from that HMO, even if they say it costs us too much, we cannot afford it.

Ms. DEPARLE. It is not clear from this one page document we got today. It says Medicare beneficiaries will have access to subsidized prescription drug coverage offered by private insures and Medicare+Choice plans. But I cannot tell whether that means M+C plans will be required to offer it or not.

Mr. MCDERMOTT. But in the President's plan no matter how I have my health care delivered, I will get my pharmaceutical benefit.

Ms. DEPARLE. Yes, sir.

Mr. MCDERMOTT. That is what I want to see. Thank you.

Mrs. JOHNSON. Administrator DeParle, did you increase the reimbursements under your plan to the managed care choice plans to account for that?

Ms. DEPARLE. Yes. It was $54 billion of our $160 billion would go to Medicare+Choice plans to provide prescription drugs.

Mrs. JOHNSON. Mr. Kleczka.

Mr. KLECZKA. Thank you, Madam Chair.

Does not the President's plan and the Democratic Caucus plan also provide some reimbursement to private health plans who currently cover a drug benefit so they are not carrying the cost of providing drug coverage themselves?

Ms. DEPARLE. Yes. These are the Medicare HMOs that we have been talking about with Mr. McDermott. To employer plans, too, yes.

Mr. KLECZKA. That is what I am referring to the employer plans. So we covered those employers who are currently offering retiree benefits so we do not disadvantage them or provide an impetus to give up their current coverage for seniors.

Ms. DEPARLE. Yes, sir.

Mrs. JOHNSON. Would the gentleman yield?

Mr. KLECZKA. Sure.

Mrs. JOHNSON. It seems to me that with a 95 percent take-up rate, since 44 percent of Medicare beneficiaries that have coverage are retirees, that they are assuming that current retirees who have prescription drugs through their place of employment will actually move into the public program, the public program will pick up those costs, and the employer will probably wrap around.

Mr. CLAXTON. I think the 95 percent assumes that most people who are in employer plans continue to stay in them, and they would receive a subsidy from the Federal Government which is less than we would pay if the people had moved to Medicare but is an advantage to the employer who is offering a plan now. So it is an incentive payment to employers to help them maintain their plans over time.

Mrs. JOHNSON. So you think they will not restructure. The subsidy will just encourage them to stay in?

Mr. CLAXTON. It is possible. They can restructure now. But we think this will substantially discourage some to restructure, because as long as they offer a benefit that is at least as good as the Medicare benefit they are going to get much more than they get today in terms of a benefit under this program and they will have an incentive to keep it in place.

Mrs. JOHNSON. Incentive to keep it, which I think is very important.

Sorry, Mr. Kleczka. Thank you for yielding.

Mr. KLECZKA. Let me apologize Ms. DeParle because we are going to be asking questions on a bill she has not seen. We are asking about a bill this Committee is going to mark up probably as early as Monday, with the anticipation of having this legislation to the floor before the 4th of July break, and we are asking you, the person who is probably the most knowledgeable about Medicare and drug benefits, questions with no bill printed before you, or before us. You are shooting in the dark, as are the members of this

Committee. I think when you are talking about a drug benefit program that is going to cost in excess of $40 billion, we should probably be more careful how we go about devising this plan. However, you and I cannot be held accountable for that because we are not in the driver's seat.

I heard the authors' comments on a provision in their bill which creates a fall back position which will be a fee-for-service entitlement benefit. You cannot describe what that provision looks like. I do not know what it is. I have looked through all the documents here and there is nothing that tells me what that is.

But let me ask a couple of basic questions about private drug-only insurance because it is not part of the President's plan nor is it part of our plan. One of the mainstays of the Republican drug benefit plan is to have private insurers offer this coverage. If you are in an area, it is hoped that two insurers would offer the coverage.

Now let's use my district of Milwaukee. Let us say that there are not two insurers around who want to do this. I have to assume that if it is that profitable a line of insurance they would be writing it now, but the fact of the matter is they are not. So if two insurers do not come into the Milwaukee area to write this, and we have seen managed care plans fall by the wayside in my city, two or three have already got out of the market because they are losing money, what is the benefit for my seniors in that scenario?

Ms. DEPARLE. Well, if the only scenario is private plans, I do not believe there is a benefit for your seniors in Milwaukee because I am not convinced that they will be there.

We both heard Mr. Thomas today describe that the bill is he working on with Mr. Peterson has a fall back so that the Medicare fee-for-service program I guess would provide a prescription drug benefit to seniors who were in an area where there was not a plan available. I am eager to see the details of that because that is where I will decide whether this is really in the beneficiaries' interest or not.

Mr. KLECZKA. One of the criticisms our proposal gets is that it is too confusing. Boy, I think their proposal takes the cake on the confusion scenario.

They also criticize the Democrat's drug proposal as putting the Washington bureaucrats in control. It seems to the Republicans are are not giving any authority to your agency, which is already set up to do something similar to this. Instead they create a brand new bureaucracy which was called MAMA and now is called Medicare Benefits Administration. Based on your experience, do you know how big this agency would have to be to provide the services that are contemplated under this bill? Are we talking one or two Federal employees, or are we talking possibly 30, 40 people administering this to 40 billion people nationwide. Do you have any guess how big "Big MAMA" might be?

Ms. DEPARLE. I do not know how big MAMA might be, but I can tell you that our——

Mr. KLECZKA. They are trading in Big Brother for Big MAMA. Nevertheless, big is still part of the equation.

Ms. DEPARLE. I think the important thing here is not to look at the size of it but whether it will be efficient and effective.

Mr. KLECZKA. I think we have to look at both.

Ms. DEPARLE. The Health Care Financing Administration has about 4,500 employees. I do not think we are big enough, frankly. We are trying to administer a program that is upward of $200 billion a year. Every single member and this Committee has been in touch with me over the past year on multiple occasions, maybe not Dr. McDermott, everybody else, about various things that you wish I were doing in your districts for your providers or beneficiaries. All of that is legitimate. But to run a prescription drug program will not be a two or three person initiative. Even if you are just contracting—we want to run this through the private sector with pharmacy benefit managers—but I believe you want us to negotiate with them and to get a good contract and to make sure they are doing their jobs. I do not think it will be a two to three person initiative.

Mr. KLECZKA. So you are saying Big MAMA is going to be pretty big to do the job right?

Ms. DEPARLE. To do the job effectively, I think you would want it to be big.

Mr. KLECZKA. I have one more question. This is one that intrigues me and I have not heard much dialog here. This new agency, Big MAMA, and I have this information from the Republican analysis of the bill, can provide financial incentives to private plans to encourage the formulation of national and/or statewide plans. That says to me that we are going to subsidize insurance companies. Is that what you understand this to read? "MBA can provide financial incentives to private plans." We have heard, and, again, there is nothing written, that the Federal Government is going to subsidize private insurance companies to provide this benefit. That is pretty important stuff. My constituents would love to know that we are subsidizing Aetna or some of the other insurance companies.

Ms. DEPARLE. That is how I read it. I do not know whether this line on this piece of paper, I assume this is an attempt to respond to the concerns many have raised about the fact that you have a managed care plan in Milwaukee and you do not have one in Kenosha. So maybe the idea is to try to encourage plans to provide statewide plans. I have no idea what kind of financial incentives it would take to do that.

Mr. KLECZKA. I think in an effort to get two insurers into a community when the insurers say this is not going to be a profitable line, Big MAMA is going to come around and say we will help you and provide for a profitable line, here is a little subsidy.

Ms. DEPARLE. That is what it sounds like.

Mr. KLECZKA. Madam Chair, thank you very much.

Mrs. JOHNSON. Thank you.

Mr. McInnis.

Mr. MCINNIS. Thank you. I would note, Madam Chairman, that earlier there were comments, I think including the witness, about how we need to come together and make an effort to come out with something that is satisfactory. I just witnessed in my opinion probably the most partisan remarks I have heard so far. It is clear to me that when we have got someone who thinks cuteness should prevail probably over common sense, "Big MAMA" and things like

that, you can understand why it is difficult for any of us to sit down and have much of a dialog.

I should point out that the previous speaker was very ardent in his remarks about the private marketplace. Sitting here, one would think that the private marketplace is entirely encompassed by HMOs. I would urge the gentleman—who clearly is not paying attention, but if he gets around to the point that he might—I would urge that he refer to the President's plan. I am sure the witness has seen this. My understanding from your previous comments is that this plan has not been altered in any way. So, assuming that it has not been changed, I would urge the previous speaker to read it. On page 22 it says "Medicare would not administer this benefit directly but would instead contract out with private sector entities." So the President's plan itself envisions a large——

Mr. KLECZKA. Would the gentleman explain what you are reading from?

Mr. MCINNIS. Sure. Page 22 of the President's plan to modernize and strengthen Medicare for the 21st century.

Mr. KLECZKA. It is the President's plan.

Mr. MCINNIS. That is what I referred to. So the President's plan encompasses a large involvement of the private sector. Isn't that perhaps because the private sector has some experience in the administration of a plan like this?

Ms. DEPARLE. Yes. And what we are doing, sir, is we are contracting with pharmacy benefit managers who now often are the ones who provide this same service to private insurance plans. The difference I think between the two plans, as I understand them, is that Mr. Thomas' and Mr. Peterson's plan would depend on private insurance plans, although today he talked about a fall back of the government, to provide the entire benefit. I think that is what we are expressing some concern about.

But, yes, you are right, we want to work with the private sector on this. That is what we put forward 2 years ago and that is where we are now.

Mr. KLECZKA. Would the gentleman yield?

Mr. MCINNIS. I will yield.

Mr. KLECZKA. I might also point out that the current Medicare Program also contracts out the claims processing. We use private industry throughout the country and we just save millions and millions of dollars because of the claims processing costs are so low per claim. So it is not unheard of.

Mr. MCINNIS. Which is exactly the point that I would like to make here. That is, there are a number of efficiencies out there in the private sector that should be realized by any of us up here who are coming up with this kind of a proposal. The difficulty that I see is that when the Committee itself, amongst our own members, begins to envision some horrible giant out there, i.e., the private marketplace. That somehow suggests it is evil to come up with a plan that is dependent on a marketplace that has served our country very well, given us pharmaceutical products that are second to none in the world. I just want to make it clear that both plans envision involvement of the private marketplace.

With that, Madam Chairman, I yield back the balance of my time.

Mrs. JOHNSON. Mr. Neal.

Mr. NEAL. Thank you very much.

I just would say in reference to something that Mr. McInnis said when he talked about the success of pharmaceuticals, and there is no question about it, that those pharmaceuticals are successful with heavy government subsidies in terms of the research. The taxpayer pays for much of that research.

Mr. MCINNIS. Would the gentleman yield?

Mr. NEAL. Yes, I would.

Mr. MCINNIS. Absolutely. I agree. I think the pharmaceutical companies have historically gotten a terrific deal from the government using that research.

Mr. NEAL. Right.

Mr. MCINNIS. I have no problem saying, just the same as we did with the Saturday morning cartoon shows that we created through our public broadcasting system, we ought to start sharing in that. You have noticed in the last 5 years or so that even our college universities are starting to realize the value of that research. You are absolutely right. I think they have received huge benefits from the government, and I think that the government ought to get something back for it. No question.

Mr. NEAL. Thank you.

Let me ask you a question that Ms. Johnson touched upon earlier, and I think it is individually and collectively on the minds of the Members of this Committee and most of the Members of Congress. The hospitals in Massachusetts are really hemorrhaging. They are really hurting. They do not seem to get much satisfaction in the conversations that they have with HCFA. Some of the comments that I have even heard Secretary Shalala offer do not seem to me to indicate that there is any relief on the horizon. Are you looking for a legislative fix? Are you suggesting that your interpretation of the Balanced Budget Act is the only one that is correct? What can we expect in a place like Massachusetts for our hospitals?

Ms. DEPARLE. Mr. Neal, I have met with hospital executives in Massachusetts as recently as last week and I have spent a lot of time talking to them, for that matter, from hospital executives from all over the country. And, yes, you are right, the hospitals believe that they need more money and that their profit margins are not what they should be.

I am not aware of what comments of the Secretary you are referring to. But I do know that she has said to me——

Mr. NEAL. She has said in the past there is no problem.

Ms. DEPARLE. I think what she said, at least what my discussions with her have been, is that she wants us to monitor the situation and let her know if there are problems with beneficiary access. That is the issue, are beneficiaries having trouble getting access to the hospital care they need. We have said all along we will be happy to work with the Congress if you believe there need to be changes. I am not aware of situations where the hospitals believe that we are not interpreting the law correctly. I think that they think we are.

Mr. NEAL. Mr. Thomas has argued that you are in a position to grant them immediate relief. I have heard Mr. Thomas make that argument.

Ms. DEPARLE. I do not believe that is correct. I would love to know what that is.

Mr. NEAL. I guess it comes down to interpretation of what we did in the Balanced Budget Act, right?

Ms. DEPARLE. Well, sir, the main——

Mr. NEAL. Most of us believe that we overshot the mark.

Ms. DEPARLE. Spending has been lower in many areas than what the actuaries and the CBO analysts projected would occur. You cannot relate that to just one cause though, sir. It is a lot of different factors. I think even the hospitals would tell you that. There have been a lot of things that have happened over the last 2 years. The Balanced Budget Act is certainly a major factor but it is not the only one.

I do not believe I have the ability to change the update for hospitals on my own. That is something that is written into the law. That was done for very explicit reasons, to achieve savings in order to extend the solvency of the Medicare Trust Fund, which it has done. So I am not aware of anything that I have the ability to change.

Mr. NEAL. When you met with the hospitals from Massachusetts last week what did they tell you?

Ms. DEPARLE. They told me that they would like to get a full market basket update next year, which is not what is in the law. They told me that their profit margins are lower than they have been in the past. A couple of them told me that managed care is also killing them. In the past, Medicare rates were higher and they could negotiate lower rates with managed care plans, and now they do not feel they can do that anymore. It was consistent I am sure with what you have heard from them. They would like relief from the Federal Government. They would like Medicare to pay more.

Mr. NEAL. If you have a chance and you talk with Secretary Shalala, would you point out to her that there are Members of this Committee, or at least singularly there is a Member of the committee who was upset with the comments that she has made that there really is no problem with what happened with the Balanced Budget Act. Because most of us here feel earnestly that there is a very serious problem and that some relief has to be granted in the near future.

Ms. DEPARLE. I will certainly pass that along. We have looked at all the information the hospitals from the various States have provided us. What we are looking at, again, is what is happening to Medicare beneficiaries. When you look at things like the profit margins, they are not as high as they have been in the past and I am sure that that is a concern when you have been expecting a certain profit margin. But what we see is that they are still generally around 10 percent. I hear you though, and I will certainly pass along your comments to the Secretary.

Mr. NEAL. Thank you.

Thanks, Madam Chairman.

Mrs. JOHNSON. Ms. Thurman.

Ms. THURMAN. Thank you, Madam Chairman.

Let me say this to my colleague, Mr. Neal, and it relates to something that you may all want to look at. There was an amendment offered by Mr. Tanner last week when we were doing the budget issue that actually was going to take whatever Medicare savings dollars that was believed to have put us on this road to a balanced budget and put it back into the Medicare Trust Fund and that could be used to make up some of these dollars. So that might be something for you all to look at.

Nancy, you were here this morning, but I am a little concerned that we have gone down a path on this Medicare choice issue that is going to lead us into an even more difficult problem if we do it with a pharmaceutical benefit. Just last week, as I have said, we have a health plan who has made the determination that they are pulling out of some of our counties. It basically says there are three major reasons for this decison—Government payments that are inadequate to meet the demand for health care services and medications; the uncontrolled and increasing financial demands of physicians, hospitals, and pharmacies, especially in counties where there is little competition; and significant losses in the three counties over the past 2 years which were the results of financial investments, while trying to make its Medicare plan work.

I think the thing that concerns me right now in the conversation is that it seems like it is just our fault because the reimbursements are so low. And I would suggest, and if you can help me here, it is maybe the pharmaceutical costs which have gone up dramatically for these plans, about 18 percent or somewhere around there, not something that we had any jurisdiction over.

The other thing, and maybe you can help me, is what I looked at what the numbers were in the areas that they are dropping out. One is Osceola County, which is not one of my counties, there was $548 for reimbursement; Hernando County was $543 reimbursement; Pasco County is $572. However, they say they are going to stay in Miami, Broward, Palm Beach. Now Palm Beach only gets $542; Hillsboro County, $460; I think Alachua County is $466. And they stay in these counties that are getting as little as $460. Now here we are talking about putting a pharmaceutical benefit through these same companies. That is not adding up to me. We have some counties that have less reimbursement and some counties that have more reimbursement, but they are all pulling out anyway. So that makes no sense.

Last year when we did the budget issue, in order to try to bring some more money back into Medicare and into Medicare+Choice, we put an incentive program in there to provide 5 percent for any plan that would go back into a county, first come first serve. Have we had any takers on that?

Ms. DEPARLE. I just checked on this a couple of weeks ago and I was told there were maybe a couple of plans that had come in. There is also a new private fee-for-service plan that has just come in. You also put some incentive payments in if they would go into areas where there were no other plans. They do not appear to have attracted many plans to come back in. I was told only a couple.

Ms. THURMAN. So if you have this fall back provision, or potentially a fall back provision when we get this legislation, we do not have any idea or belief that this would bring people back into the

plans or into a Medicare+Choice plan or through private insurance. We are not seeing that now, are we?

Ms. DEPARLE. No. It is too early yet to figure out what the trend is and the withdrawals. But it does seem, as you say, that they are staying in some counties that you would wonder why. But when I talk to the executives, what they tell me is it is not just the base payment amount, it is also whether they have a network in place, what their loss ratios have been, in some cases they stay in an area because it is adjacent to a county where they intend to make a commitment, and there are other things at work. But it is a business decision that they make on a yearly basis.

My concern is I do not want to have the entire Medicare prescription drug benefit rest on that. I want this to be a guaranteed benefit.

Ms. THURMAN. I do not want a two-tier program. I do not want it in some areas where we have HMO and some where we do not have these services for Medicare. We actually are just breaking Medicare down under these conditions.

I need to go to something that Ms. Johnson said, because this is what is happening in my counties on the prescription drug issue, at least this is what I have been told. Because of lower payment, my constituents would have to pay a $95 premium. It has gone from about $45 to $95. So they are paying about $1,140 a year. They are probably getting about an $800 of actually prescription coverage. That varies because they get a $5 copayment if they get a generic drug, they get a $10 copayment if they go up a little higher, if they do not stay within the formulary then they have to pay 50 percent of the drug cost and on top of that, at the end of that cap part that they have, they would get used to the idea of paying 50 percent of what they have as their negotiated price. So I do not see where they are getting a great benefit under the programs that we seem to be trying to push everybody into.

Mrs. JOHNSON. If you would answer very briefly, because we have two more questioners and another panel yet. So we are concerned about what we are doing to the other panelists' schedules.

Ms. DEPARLE. I share your perplexity I guess about this. There are cases where it does not appear to be a very good deal for beneficiaries. But, unfortunately, in some of those cases, even though it is not a great deal, it might be slightly less expensive than buying Medigap policies in that area.

Mrs. JOHNSON. Mr. Doggett.

Mr. DOGGETT. Thank you very much.

That, in fact, leads right into my line of inquiry. I read your written testimony which indicates that the administrative costs of Medigap insurance is about ten times as much as the administrative costs for Medicare. Is that correct?

Ms. DEPARLE. Yes. That has been our experience.

Mr. DOGGETT. And so if our goal is to have the most cost-effective program to try to get prescriptions to our seniors need, relying on a Medigap-type system is going to be not the best choice.

Ms. DEPARLE. That is one of our concerns. As Mrs. Johnson said earlier, the devil is in the details. We do not know where the administrative costs for these Medigap plans are going to be.

Mr. DOGGETT. It would not appear to be in the taxpayers' interest to use a system that is ten times less efficient than the one we have now for Medicare.

Ms. DEPARLE. I would be very concerned about that.

Mr. DOGGETT. And then, as you know from my inquiries this morning, I am very concerned that we will simply shift the burden of outrageous prescription drug prices from seniors to the taxpayer. Let me ask you, as a preliminary question, and I know this is not what is contemplated, but is there any way that we could sustain a program where the government paid the same retail prices that uninsured seniors have to pay now for their prescriptions?

Ms. DEPARLE. That would be terribly expensive.

Mr. DOGGETT. Terribly expensive.

Ms. DEPARLE. I would not propose to do that, no.

Mr. DOGGETT. And we know now that some seniors just do not get the prescriptions they need because they cannot pay retail. And you would not reasonably propose that the taxpayer pay retail.

Ms. DEPARLE. No, sir, I would not.

Mr. DOGGETT. You have already had in your work some experience, in fact some fairly recent experience, with this so-called average wholesale price, have you not? What has been your experience with the way the pharmaceutical industry sometimes handles its prices for Medicare and Medicaid?

Ms. DEPARLE. What we are trying to do is make sure that Medicare pays a fair price. We think that the law right now provides that Medicare pays for the drugs that it provides incident to a physician's services. It is supposed to pay 95 percent of the average wholesale price. For that, we rely on some industry published data.

Mr. DOGGETT. Is that the Red Book?

Ms. DEPARLE. Yes, the Red Book and the Blue Book, which turns out to be wrong. It turns out to be not what is really the wholesale price. So what we have been trying to do is work with the Justice Department to find out what the actual prices are that are paid at the wholesale level so that we can make sure that Medicare gets the advantage of paying those lower prices. But it has been a terribly frustrating and difficult exercise.

I also want to mention that the President has for the last four or 5 years now proposed a law to help us to be able to do this better, to make sure that we get the prices that physicians actually are paying. With that, we have said we would like to make sure that we are paying physicians appropriately for administration of those drugs. That is something that this Committee has raised. But we want to make sure Medicare pays a fair price.

Mr. DOGGETT. What you are saying is that there have been, I believe, four occasions when the administration has come to the Republican Congress and said please give us the tools to ensure that the taxpayer is not being ripped off and that they are paying the actual wholesale price and not some contrived wholesale price. And you have been unable on each of those four occasions to get the tools that you need to protect the taxpayer and to get reasonably priced prescription drugs?

Ms. DEPARLE. Unfortunately, yes, that is the case.

Mr. DOGGETT. You mentioned the Justice Department. What is the status, at present, of your efforts to see that the taxpayer, even

with the limited tools that you have, is not being ripped off by outrageous prescription drug prices?

Ms. DEPARLE. Working with the Department of Justice and its investigations, we are compiling better information about what prices wholesalers are actually paying. We intend to get that out to our carriers, the private insurance companies that pay Medicare's bills, so that they can start using those prices and reimbursing at that rate. Then we would still love the opportunity to work with this Committee and with the Congress toward a proposal like the President's proposal that we think will do a better job of ensuring that Medicare pays appropriately instead of paying these inflated prices that are not the wholesale price.

Mr. DOGGETT. Thank you so much.

Mrs. JOHNSON. Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chair.

I do not know why we are making this so complicated, quite frankly. Medicare does a good job of holding down costs. I think all of the statistics we have seen show that Medicare costs have been certainly comparable to what is happening in the private sector as far as cost-containment. Of course, a lot of my providers think you are doing too aggressive a job on cost-containment.

My first question is why would we want to treat prescription drugs differently than any other necessary medical service, whether it is a physician, whether it is equipment, or whether it is a hospital? Why would we want to discriminate against prescription drug coverage? Why would we not just make it a part of the basic benefit package and allow a fee-for-service option and any other options that could come along?

My one complaint about the administration's proposal is that I do not think you put enough money into the proposal. Quite frankly, the costs are a lot higher than you are willing to share, which means our seniors are going to have to incur a significant part of the cost of prescription drugs.

But what I really want to lead you through and try to get your response to is this: I do not understand how Mr. Thomas' numbers add up. Maybe you can help me with this. You made a point earlier that I thought was very telling, and that is, the success of a program depends upon a significant number of people participating so you do not get adverse risk selection.

Ms. DEPARLE. That is right.

Mr. CARDIN. It seems to me that Mr. Thomas' proposal may work just the opposite; that is, he is fitting his plan into the dollars that are available by having a lot of people not participate. We do not know, because it depends upon the voluntary selection. His subsidy will not be as high. The premium amount that the individual will have to pay appears to be a higher percentage than you have in your plan. His proposal it is going to be dependent upon private insurance so there is no guarantee that individual will be able to get a defined plan that is spelled out by statute if there are two private plans in their community. And we are not sure about the cross-subsidies between the catastrophic proposal and the basic proposal, at least we do not know that yet.

So it would seem to me that there is a high risk that part of the reason why his proposal fits into the $40 billion that is in the budg-

et resolution is that there are going to be a significant number of seniors that will not be participating.

And this really gets me back to one of Mr. McCrery's observations earlier about Senator Kennedy's numbers of 12 million versus 6 million beneficiaries. It seems to me that one of the factors we should be considering is that this program will not be successful if we do not entice enough seniors to participate because we are going to be running the risk of adverse risk selection. That is why the lack interest of the private insurance industry in this area was raised earlier—because of the concern about adverse risk selection.

Mr. MCCRERY. Would the gentleman yield?

Mr. CARDIN. I would be glad to.

Mr. MCCRERY. Since Mr. Thomas is not here to defend his plan, which is admittedly not quite public yet. I can assure the gentleman that all of his questions have been asked to CBO, to actuaries, and that CBO is taking into account all of those considerations in assessing the cost of the proposal. I think the gentleman will be pleased when he sees the results.

Mr. CARDIN. I hope so. If I understand, and maybe, Mr. McCrery, you would like to respond to this, if I understand it, you are going to have an actuarial equivalent amount of which part will be paid for by the premium and part of the actuarial equivalent will pay for a catastrophic benefit. So, therefore, the individual who is trying to decide to join the plan or not will be looking at a benefit package that is going to be an actuarial equivalent of $500 or $600 a year, and paying a premium of $35 or $40 a month for it. It seems to me that it will be very difficult to attract a large number of seniors into that type of program. I just do not think it is rich enough.

Mr. MCCRERY. If the gentleman would yield one more time.

Mr. CARDIN. Sure.

Mr. MCCRERY. The actuarial equivalent we expect to be considerably higher than $500 to $600.

Mr. CARDIN. I thought it was $750 or something like that.

Mr. MCCRERY. Well that is higher than $500 or $600.

Mr. CARDIN. But part of that involves the catastrophic, does it not?

Mr. MCCRERY. Sure.

Mr. CARDIN. Well the individual who is buying the plan, yes, will be looking at the catastrophic but will be making the judgement based upon the benefits that they are going to be getting on an ongoing basis, which will be a very small benefit or a very high premium.

Mr. MCCRERY. Not necessarily. If you have a 30 percent subsidy, that is not a bad deal. If you are now having to pay the highest prices in the market for pharmaceuticals and you have no drug plan available to you, then it might look like a pretty good deal if you can get better prices for drugs and a 30 percent subsidy.

Mr. CARDIN. Reclaiming my time, because it is almost over. It seems like you are rolling the dice on that. Unless you put it in, and we get back to the same point, unless you make it part of the defined benefit, core benefit of Medicare, we run a very, very heavy risk that the actions of private insurance companies will determine

whether our seniors are going to have adequate coverage in their community.

The one good thing about the fee-for-service program is that every senior any place in this country can get that fee-for-service benefit at the same cost. The problem with Medicare+Choice is it varies around the nation, the private insurance varies around the nation. We are partially responsible for that. We all acknowledge that. It is clear that the approach that you are taking of providing incentives to the private insurance market will mean there will be different plans around the nation that have different cost factors depending on where beneficiaries live. So we are going to have the same problems we have today with Medicare+Choice.

Mrs. JOHNSON. Will the gentleman yield?

Mr. CARDIN. I would be glad to.

Mrs. JOHNSON. Actually, it turns out that the premium I think will shake out in the Thomas proposal to be almost exactly, maybe slightly under, a few dollars under, what the premium is in the President's plan plus what the CBO estimate is for a premium for catastrophic. So I think we are not going to be way off, frankly, when we begin to talk about premiums and what they are going to cover.

As for there being national variation, there is going to be national variation when you negotiate with one regional pharmaceutical benefit manager in price and what you get.

Mr. CARDIN. Just very quickly, if I may. My concern is I just do not know how the Thomas proposal fits into the dollars that are available. The Administration is admitting openly that they cannot do it for $40 billion and include a catastrophic plan unless there are going to be high premiums for it. I just do not know how your bill will do it for the $40 billion.

Mrs. JOHNSON. If you add their bill and the premiums in their bill plus what CBO estimates for a premium for catastrophic, you come out roughly where we are. That is what we are going to be looking at.

I apologize, I do have to call the next panel. I would like to thank the Administrator for being here. I would mention that you will be getting a letter from some of us who are very concerned about your interpretation of the President's administrative action with regard to cancer clinical trials. That is that the routine patient costs are being interpreted, at least we believe they are being interpreted, more narrowly than they were in our legislation. So we look forward to working with you on that. Because if your regulation is not what the cancer community considers satisfactory and what is in our legislation, then we will have to proceed with estimates and changing the law.

Ms. DEPARLE. I look forward to seeing your letter.

Mrs. JOHNSON. Thank you.

Ms. DEPARLE. Thank you. We wanted to include in the practice, the expenses and physician reimbursements of the cost of delivery of oncology drugs because if not, we are going to disadvantage particularly rural cancer victims in terms of treatment options.

Mrs. JOHNSON. As a matter of fact, that relates to the issue Mr. Doggett raised with me and I said that I wanted to talk to the on-

cology community about what they think is necessary. I have done a lot of work in that area and I am anxious to be involved.

Ms. DEPARLE. You raised this with me a couple of years ago.

Mrs. JOHNSON. We are going to hear now from the seven speakers on our last panel: Karen Ignagni, President and chief executive officer, American Association of Health Plans; Craig L. Fuller, President and chief executive officer, National Association of Chain Drug Stores; Judith H. Bello, Executive Vice President, Policy and Strategic Affairs, Pharmaceutical Research and Manufacturers of America; Deborah Briceland-Betts, Executive Director, Older Women's League; Patrick B. Donoho, Vice President, government Affairs and Public Policy, Pharmaceutical Care Management Association; Stephen W. Schondelmeyer, Head, Department of Pharmaceutical Care and Health Systems, and Professor, Pharmaceutical Management and Economics, University of Minnesota; and Charles N. Kahn, III, President, Health Insurance Association of America.

Karen, you may start.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF HEALTH PLANS

Ms. IGNAGNI. Thank you, Madam Chair.

I would ask that my testimony be submitted for the record.

Mrs. JOHNSON. All testimony will be included in the record.

Ms. IGNAGNI. We appreciate this opportunity to testify. I am Karen Ignagni, President of the American Association of Health Plans. I would like to make several points.

First, our members support creating drug benefits for Medicare beneficiaries. In our view, it is long overdue, and it is a matter this Congress can and should confront. Making prescription drug coverage available is an essential part of the effort to bring the 1965 program into synch with the benefits programs of today. Our sustained economic expansion and prosperity should allow us to ensure that Medicare beneficiaries have access to affordable prescriptions over time and put an end to the draconian challenges that individuals face in terms of food, fuel, prescriptions and other tradeoffs.

An essential part of achieving this objective will be to build on what works. To that end, we are encouraged that choice is a key principle within so many proposals that have been submitted and discussed today and that there is a growing recognition about the need to preserve what exists as a building block for taking the next step. Many health plans that particpate in Medicare+Choice already provide drug coverage to millions of beneficiaries who otherwise wouldn't have access. However, in little over 3 weeks, our plans face the deadline by which they need to let HCFA know whether they are going to be forced out of more counties or be able to continue to particular in the program.

Health plans are facing these difficult decisions for a number of reasons. One, because of unintended consequences associated with the Balanced Budget Act and two, the sheer number of regulations and instability and lack of predictability in the regulatory environment. To her credit, the Administrator has begun not only to recog-

nize this situation but also to take some action toward that end in addressing it.

We urge you to act now to preserve the Medicare+Choice program that provides so many low and moderate income beneficiaries who have few other affordable options with additional coverage. They receive protection from high, out of pocket costs; they receive catastrophic benefits and prescription drugs. Also, I would note that because there has been discussion this afternoon about rural areas, that the issue with respect to managed care participation in rural areas may have more to do with the unwillingness of certain single provider systems to contract with managed care organizations versus willingness of plans to participate themselves.

In our testimony, we have offered principles for your consideration with respect to designing prescription drug programs. These principles are embedded in many of the proposals being discussed here today. In our view, they begin with the concept of universality that all beneficiaries should be eligible for the benefit, that there should be subsidies for low income individuals that there should be sustainable funding over time and that there should be options and flexibility.

We stand ready to work with you to contribute to the Committee's efforts and support the objective which we know all of you share of providing affordable coverage for this beneficiary population.

Thank you.

[The prepared statement follows:]

Statement of Karen Ignagni, President and Chief Executive Officer, American Association of Health Plans

I. Introduction

I am Karen Ignagni, President and Chief Executive Officer of the American Association of Health Plans (AAHP—. On behalf of the more than 1,000 HMO, PPO and other network-based health plans that are members of our association, I am pleased to testify this morning on the vitally important issue of extending prescription drug coverage to this nation's 38 million Medicare beneficiaries.

It bear mentioning that our membership includes the majority of Medicare+Choice organizations, which collectively serve more than 75 percent of those beneficiaries who have chosen Medicare managed care over the traditional fee-for-service option. As such, we are delighted that Congress is focusing so much attention on this urgent priority that affects so many American seniors and their families.

II. Prescription Drug Coverage Critical to Medicare Program

We believe that creating an affordable prescription drug benefit under Medicare is the single most important piece of unfinished business this Congress can and should confront. Not because the issue is important to those who will play a role in actually delivering a prescription drug benefit, but because it affects so profoundly the lives of Americans who have given so much to our nation and to the generations behind them.

We owe it to these millions of Americans—the men and women that have a eloquently been called the "Greater Generation"—to ensure that no Medicare senior in this nation faces the cruel reality of having to decide between paying for drugs or the monthly food bill.

Our great economic expansion—which has created so much prosperity for so many—must now be big enough to accommodate a simple proposition: that Medicare seniors deserve access to affordable prescription drugs. And that no one will be left behind.

When established in 1965, Medicare reflected the state of the art in health care delivery and benefits design. At that time, few people with private health insurance had coverage for prescription drugs. Today, most commercially-insured individuals receive care through managed care plans, and prescription drug coverage is the norm, not the exception. Prescription drugs have transformed the treatment of innu-

merable illnesses and conditions and have improved the quality of life for millions of Americans. Access to prescription drugs is particularly crucial for Medicare beneficiaries. Although the elderly comprise 12 percent of the population, they account for 34 percent of total prescription drug costs (Mueller, 1997). It is estimated that individuals over the age of 65 use four times as many prescription items as those under 65. Prescription items are common treatment regimens for chronic conditions, which are highly prevalent among the elderly. Health plans and disease management companies have pioneered programs to help individuals with chronic conditions, such as congestive heart failure and cancer, among others, to maintain their health, and prescription drugs are a central component of these programs.

III. Medicare+Choice Programs Is Critical to Ensure a Strong Foundation for Prescription Drug Coverage

We believe that Congress can deliver a prescription drug benefit to America's seniors through a bipartisan effort, and that members can create a system that is faithful to Medicare seniors and indeed all Americans.

The job won't be simple. And the choices won't be easy. But the first step is to listen closely to what seniors really want from their Medicare system, and to build upon what's already working in the marketplace.

First and foremost, seniors are telling us that they want control over their health care to rest with them, not with Washington. That means preservation of choice...so that Medicare seniors can choose a prescription drug benefit that's right for their unique needs and wants, and that no one gets locked into a one-size-fits-all system.

Second, we can't find common ground by, in essence, throwing out a coverage option that has proven to be effective. Managed health care has played a significant role in providing an affordable prescription drug benefit to most of the 6 million seniors who have chosen the Medicare+Choice option. The simple fact is that managed health care has already played a role in expanding a prescription drug benefit under Medicare to millions of Americans who otherwise would not have had access to it.

Building on that success—instead of allowing Medicare+Choice to remain in a state of crisis—is the first significant step we can make to answering the Medicare prescription drug challenge that has been laid before us.

AAHP's member plans have had a longstanding commitment to Medicare and to mission of providing beneficiaries high-quality, comprehensive services and lower out-of-pocket costs. Many of our member plans have served beneficiaries since the inception of the Medicare HMO program as a demonstration project. Recent studies highlight Medicare beneficiaries' high levels of satisfaction with their Medicare health plans. HCFA data show that, among beneficiaries who identified themselves as having strong preferences, HMOs have a larger proportion of very satisfied enrollees than fee-for-service Medicare.

Beneficiaries's satisfaction with the program was further demonstrated last month, when ore than one hundred beneficiaries who have chosen a Medicare+Choice plan over the fee-for-service delivery system came to Washington to talk about the importance of having a choice of coverage, having additional benefits, and having protection from higher out-of-pocket costs.

Health plans participating in the Medicare+Choice program have long recognized the importance of prescription drugs in meetings their members' health care needs. In fact, almost 70 percent of plans and most of the more than 6 million beneficiaries enrolled in a Medicare+Choice plan have a prescription drug benefit. A recent AAHP analysis of HCFA data showed that many of these beneficiaries are "unsubsidized"—meaning they do not receive any third party assistance from, for example, a former employer or through Medicaid, in purchasing supplemental coverage for prescription drugs. **Specifically, AAHP found that a majority of unsubsidized beneficiaries with coverage for prescription drugs were enrolled in health plans** (see attachment: "Financially Vulnerable Medicare Beneficiaries Rely on HMOs for Prescription Drug Coverage"). Without this option, these financially vulnerable beneficiaries undoubtedly would be forced to forego medication therapies that would help maintain their health and improve their quality of life. This is why we believe it is critically important to assure that Medicare+Choice beneficiaries maintain the important benefits they currently receive through their Medicare+Choice plans.

The promise made to beneficiaries in the 1997 Balanced Budget Act (BBA) of a stable Medicare program that offered a wide array of choices all over the country to allow beneficiaries to meet their health needs in the most effective way possible has yet be fulfilled. Unintended consequences of the BBA have resulted in beneficiaries who chose to join a health plan losing benefits, facing sharp premium increases, and, in many instances, losing the option of even remaining in the plan of their choice. Since enactment of the BBA, nearly 700,000 beneficiaries have had

their Medicare+Choice coverage disrupted. Already, a number of plans have announced that they will be forced to exist the program effective January, 2001 because of inadequate funding and excessive regulatory burdens.

Last year, this Congress, in passing the Balanced Budget Refinement Act of 1999 (BBRA), took the first steps to correct the BBA's unintended consequences. The phase-in of HCFA's risk adjuster was slowed in order to minimize its impact on Medicare+Choice enrollees. Among other changes, Congress expressed its intend that the risk adjuster be budget-neutral rather than used to reduce total payments on behalf of seniors and individuals with disabilities who choose a Medicare+Choice plan; and user fees for the beneficiary information campaign were fairly apportioned. We appreciate the work of members of this Committee in recognizing the importance of Medicare+Choice and in advancing proposals to further stabilize the program. We strongly urge you to take bold measures this year to preserve beneficiary choices and avoid any further disruptions in coverage. These efforts are crucial to ensuring a strong foundation for the effort to expand prescription drug coverage.

IV. AAHP Principles and Issues for Consideration in Expanding Access to Affordable Prescription Drug Coverage

Again, AAHP member plans favor expanding access to prescription drug coverage. This topic was central among those discussed by our Board of Directors last winter. AAHP's Board believes that beneficiaries deserve a wide variety of coverage choices. Recognizing that all beneficiaries do not have the same needs and that many have already exercised their choice of coverage, our Board committed to conveying the importance of respecting choices currently available and minimizing any disruption of these choices. Our Board approved the following principles on prescription drug coverage:

- **Enhance Coverage of and Financial Support for Prescription Drugs:** Any proposal to expand prescription drugs coverage should reflect Medicare's underlying philosophy of universality. All beneficiaries should have equivalent financial support for affordable prescription drug coverage. Additional financial support should be made available for those with special needs.
- **Sustainable and Actuarially Sound Funding that is Equivalent Across All Funding Options:** Expanding prescription drug coverage will increase total Medicare spending. The additional costs should be supported by a responsible and sustainable financing mechanism, not on a discretionary basis. Any sustainable initiative should be designed with the incentives needed for a stable private sector delivery system. Federal contributions should be equivalent across all coverage options. New funds dedicated to prescription drugs coverage should include options that have previously provided prescription drug coverage.
- **Allow Beneficiaries a Range of Options So They Can Select Coverage That Best Meets Their Needs:** Any proposal should recognize various existing coverage options and other potential innovative solutions and should retain beneficiaries's ability to select the option that best meets their coverage needs.
- **Meet Beneficiaries' Needs through Flexibility in Benefit Design and Effective Delivery Strategies:** Flexibility in benefit design and strategies that promote the effective use of prescription drugs are critical features of effective drug coverage. Should an initiative link financing to a minimum benefit, entities that offer coverage should be allowed to structure benefits that meet or exceed this minimum according to an actuarial equivalence or similar standard. Likewise, strategies—such as formularies, generic substitution, and programs to prevent problems associated with use of multiple prescriptions—are essential to high-quality coverage for beneficiaries. Permitting flexibility in structuring coverage will promote broader choices and better care for beneficiaries.
- **Minimize Disruption of Benefits Among Beneficiaries Who Currently Have Coverage By Ensuring Equity and Value in the Government's Contribution:** Recent reductions in government funding have forced many Medicare+Choice plans to reduce the scope of their prescription drug benefits or to increase beneficiary cost-sharing. Stabilizing the Medicare+Choice program is crucial to prevent the further erosion of benefits and coverage choices. Although the Balanced Budget Refinement Act of 1999 (BBRA) was a good first step toward this end, much work remains to ensure that the promises made to beneficiaries with the passage of the BBA will be fulfilled.
- **Preserve Access to Integrated Health Care Benefits:** Health plans that offer prescription drug coverage have sought to fully integrate this benefit into coverage that Medicare enrollees receive. For example, medication therapy is a central component of health plans' disease management programs, which coordinate the delivery of health care services to beneficiaries with chronic conditions. Any proposal

should preserve health plans' abilities to incorporate prescription drugs into an integrated benefits package.

In addition, proposals to expand prescription drug coverage for Medicare beneficiaries must address the difficult issue of adverse selection. To be viable, a program must strongly encourage beneficiaries to begin purchasing coverage when they are using few prescription drugs, rather than when they need or anticipate the need to use many prescription drugs. Failure to address this issue could jeopardize the Committee's efforts by undermining every organization's long-term ability to offer affordable prescription drug coverage.

To expand on the issue of flexibility in benefit design and management, we urge the Committee to consider the implications of state requirements governing prescription drug coverage. Simply stated, the application of state mandates or restrictions limits plans' abilities to design affordable prescription drug benefit packages that best meet beneficiaries' needs. Although the BBA preempts state benefits mandates, HCFA has interpreted the BBA preemption to exclude state cost sharing standards related to those mandates. The consequences is that a Medicare+Choice plan that offers benefits beyond the fee-for-service benefits package, such as prescription drug coverage, may be bound by the cost sharing requirement in state law. Another concern involves state requirements related to benefits management and administration. We support clarifying the preemption language so that state requirements so not prohibit health plans from managing benefits effectively and achieving the goal of maintaining the affordability of coverage over the long-term. A federal benefit will not remain affordable if state law requirements still restrict flexibility.

V. Conclusion

The American Association of Health Plans (AAHP) and its member plans stand ready to contribute as the Committee continues its deliberations on the best way to expand access to affordable prescription drug coverage. We have tried today to contribute to the Committee's dialogue and pledge any further assistance on the issues of expanding prescription drug coverage, broader Medicare reform, and the need to preserve the Medicare+Choice program as an important building block toward these objectives.

As you move forward with specific legislative proposals, we urge you to allow beneficiaries a range of options so they can select coverage that best meets their unique needs and circumstances. At the same time, please assure that beneficiaries maintain control over their health care choices and do not lose any of the coverage options they currently enjoy. Any legislation Congress enacts this year should place a high priority on protecting the benefits and choices of Medicare beneficiaries who currently receive prescription drug coverage through Medicare+Choice plans.

AAHP is pleased that Congress is addressing this critical issue of prescription drug coverage for Medicare. As described today, our health plans have significantly contributed to the ability of beneficiaries to access prescription drugs. We thank you for the opportunity to testify.

Mr. MCCRERY [Presiding]. Thank you.

Mr. Fuller?

STATEMENT OF CRAIG L. FULLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL ASSOCIATION OF CHAIN DRUG STORES, ALEXANDRIA, VIRGINIA

Mr. FULLER. Thank you, Mr. Chairman and Members of the Committee.

My name is Craig Fuller. I represent the National Association of Chain Drug Stores. We have 150 retail chain members, approximately 32,000 chains, filling about two-thirds of the three billion prescriptions written every year. I have submitted a statement for the record and I would like to just hit a few of the highlights very briefly.

We have been at work for several months on a plan we call Senior Rx Goal because we were concerned that in the time remaining,

this Congress would not be able to come together on a plan to provide prescription benefits for needy seniors. Our plan is a State-based plan, forward-funded which would amount to a cost of about $41 billion over 5 years, $30 billion of which would be required from the Federal Government.

We think it is a way to provide those seniors at 200 percent of the poverty level and below who do not now have prescription coverage with coverage. It would sunset in 5 years and it would give the Congress the time and the administration time to sort out both major Medicare reform as well as the drug benefit.

Having said that, we apply three important tests to our plan and other plans we look at. Perhaps we are at the same disadvantage as everyone else today which is working off a document that might be 36 hours old but I would like to make a few comments about the plan that we have seen.

Our first test is that we really believe something has to happen this year for needy seniors. So the first test is really doing something with a sense of urgency that would produce results this year. The kinds of issues you have had discussed with you throughout the day are ones that concern us. Certainly the issue of insurance is one that concerns us and the availability of the kind of plan that is envisioned. That is for this Committee to debate.

The second test is really very critical. It is that any successful plan, in our view, must enhance patient safety and improve patient outcomes. We must not settle for an approach that fails to safely care for seniors who generally have a more intense need for prescriptions as well as medication management. We know the Members of Congress are concerned about this. We think this needs to be an important consideration as you look at these plans.

The proposal that has been outlined by Mr. Thomas today would involve a 'drug only' insurance program that Medicare beneficiaries could purchase in the private marketplace. These policies would likely be administered by pharmaceutical benefit managers or PBMs as they have been discussed and described today.

We have a high degree of respect for what PBMs do for their clients, but at the end of the day, it is not insurance companies and it is not PBMs that provide patient care. It is the community pharmacist, and a one-on-one relationship with that patient.

We do think because seniors need more intense care, medication management, disease management, refill reminders and consistent monitoring, that they need the active involvement of a pharmacist in the community pharmacy setting. We are not sure that a drug only insurance plan would provide that, at least as it has been outlined to us at this date.

We believe that any new Medicare prescription drug plan should assure that these important programs are a part of the standard benefit package, just like the prescription drug product, especially for seniors most at risk for potential medication-related, adverse events.

We also believe it is important that legislation assure that pharmacists have adequate time and proper incentives to deliver these important quality improvement services for Medicare beneficiaries.

This brings me to the third point and final test, which is that there is a fair return for pharmacy, and that any successful plan

should assure that the highly efficient, community pharmacy infrastructure which operates on a 2 percent net profit margin today, remains viable to serve the health care needs of all Americans.

I am not suggesting that the entire issue of pharmacy reimbursement for public health care programs can be tackled by this Committee, at least in this session, but I do want to point out that PBMs and the marketplace process that is in place today tends to focus most of the cost containment on pharmacy providers. This has resulted in a steady reduction of margin at the pharmacy level.

I want to just touch upon a point, and I know we are working off an outline that may or may not be current, but there is an element in there that brings on price controls on pharmacies that I want to single out. The plan, as we have seen it, would allow PBMs to mandate a certain price that pharmacies could charge Medicare beneficiaries for prescriptions after their coverage has reached the cap. In other words, once that coverage is exhausted, the outline we have seen suggests that the pharmacy would still have to provide payments at this negotiated lower price.

Again, we think that is an element of price control that would we would be concerned about. We would like to work with the Committee in an effort to resolve that particular issue.

I will close by saying we commend this Committee for the work it is doing. This is a critical issue. We really would like to see a resolution that provides relief this year for needy seniors. We think with the press of time, a broader plan cannot pass; a State-based plan could be funded along the parameters that have been laid out by this Congress that would be made available and would give you the time to work on a broader, more comprehensive plan.

Thank you.

[The prepared statement follows:]

Statement of Craig L. Fuller, President and Chief Executive Officer, National Association of Chain Drug Stores, Alexandria, Virginia

Mr. Chairman and Members of the Committee. I am Craig Fuller, President and Chief Executive Officer of the National Association of Chain Drug Stores (NACDS). I appreciate the opportunity to appear before you today to discuss various legislative proposals to cover prescription drugs under Medicare, and their impact on Medicare beneficiaries and community retail pharmacies.

NACDS represents more than 150 chain pharmacy companies that operate over 32,000 community retail pharmacies in the United States. The NACDS membership base fills about 62 percent of the approximately 3 billion prescriptions that are dispensed each year in the United States. We employ approximately 94,000 pharmacists in our stores.

First and for the record, let me say that NACDS and its members applaud the significant time and effort that you have contributed to the debate about the best way to expand prescription drug coverage to Medicare beneficiaries. We understand and appreciate the need to improve prescription drug coverage for seniors. Every day, we see the impact on people who too often must choose between the food they need to sustain them, and the medication they need to treat an illness.

As many of you know, NACDS has been working for several months on a state-based plan that would fund a prescription benefit plan for needy seniors that we call SenioRxGold. SenioRx Gold is supported by a coalition of groups, including the American Pharmaceutical Association, the American Society of Consultant Pharmacists, the Food Marketing Institute, and the National Consumers League.

While the specifics of "The Medicare Prescription Drug and Modernization Act" are new to us, because of our work on SenioRx Gold, we have a pretty clear idea of the critical elements that must be considered if real prescription drug assistance is going to reach those who need it most. Indeed, we have attempted to apply three important tests that we believe should be applied to any proposal designed to enhance prescription drug coverage for seniors.

Sense of Urgency

First, we need a national sense of urgency about reaching needy seniors across America *this year* with a program that allows them to receive the prescription medication they and their doctor agree they need. Frankly, the leadership in Congress has repeatedly stressed the importance of meeting this challenge, and with these hearings today, your committee is expressing an urgency, which we fully commend.

However, as you are aware, the insurance industry has expressed concerns about the viability of private-market "drugs only" insurance proposals, calling them "unworkable" and raising serious questions about whether they would amount to nothing more than "unfulfilled" promises to needy seniors.

We also know from experience that the Balanced Budget Act of 1997 created various other types of health insurance and provider options for Medicare beneficiaries, which have not come to fruition. We are concerned that "drugs only" policies would meet the same fate.

Enhance Patient Safety/Improve Patient Outcomes

Second, any successful plan must enhance patient safety and improve patient outcomes. We must not settle for an approach that fails to safely care for seniors, who generally have more intense prescription medication management needs than non-senior populations. We know that Members of Congress are truly concerned about structuring a benefit that provides medication management programs for seniors.

The House leadership proposal would create "drugs only" insurance policies that Medicare beneficiaries could purchase in the private marketplace. These policies will likely be administered by pharmaceutical benefit managers—or PBMs. As you know, community retail pharmacy has a significant amount of experience in dealing with PBMs.[1]

For the record, let me state that, with all due respect, insurance companies and PBMs do not manage care—pharmacists do—and we have helped manage health care for years. The role of the pharmacist in reducing the risk of conflicting medications and in assisting patients with proper dosage and usage requirements is a well established, critical element of healthcare delivery.

But seniors need more intense care—medication management, disease management, refill reminders, and consistent monitoring. Will "drugs only" insurance plans be structured so that we are providing both prescription drugs *and* important medication therapy management programs to seniors?

We believe that any new Medicare prescription drug plan should assure that these important programs are part of the standard benefit package—just like the prescription drug product—especially for those seniors most at risk for potential medication-related adverse events.

We also believe that it is important that legislation assure that pharmacists have adequate time and proper incentives to deliver these important quality improvement services for Medicare beneficiaries.

Fair Return for Community Pharmacy

Which leads me to my third point: any successful plan should assure that the highly-efficient community pharmacy infrastructure—which operates on 2 percent net profit margins—remains viable to serve the health care needs of all Americans. I'm not suggesting that the entire issue of pharmacy reimbursement for public health care programs be tackled by this committee (at least in this session), but I do want to point out that PBMs tend to focus most of their cost containment on pharmacy providers. This has resulted in a steady reduction of margin at the pharmacy level. I want to point out that language currently in the proposal allows PBMs to aggressively negotiate discounts from pharmaceutical manufacturers, you should be aware that a 1998

Much of the savings that PBMs achieve appear to come from the lower prices paid to pharmacies rather than from the rebates offered by drug manufacturers.[2]

Moreover, the plan before us today would allow for "price controls" on retail pharmacies. That's right—the plan before us today would allow PBMs to mandate a certain price that pharmacies could charge Medicare beneficiaries for prescriptions

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[1] According to IMS Health, almost 75 percent of prescriptions filled in a community pharmacy were paid for with cash outside of a plan in 1990. Now, almost 85 percent of all prescriptions are paid for by plans—most with a prescription benefit manager involved.

[2] Congressional Budget Office, *How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry,* July 1998, p. 8. The study found that 50 to 70 percent of the drop in the plans' spending on prescription drugs resulted from lower retail prescripton proices. Only 2 to 21 percent of the savings resulted from manufacturers debates that the PBMs shared with the health insurance plans.

after they have reached their coverage cap. We are unsure why Congress would impose price controls on a highly competitive industry that operates on a 2 percent net profit margin. We urge Congress to reject price controls on retail pharmacies.

Conclusion

Mr. Chairman, I'd like to conclude by saying we recognize that these are serious and difficult issues and we appreciate your leadership and that of members of your committee for bringing this important legislative proposal forward for review and discussion. You, members of your committee and your staffs have encouraged us to be frank and candid during this entire process. We would be pleased to work with you in addressing some of the concerns I have outlined in my testimony. We think, as I suggested earlier, that there are several reasons we can provide an important perspective.

Finally, I will end by saying that we also remain committed to the notion that if the Medicare Prescription Drug and Modernization Act cannot be advanced in the shortness of time, we hope given the sense of urgency you and others have shown for the millions of needy seniors and their families, that you would consider turning to the state-based program we call SenioRxGold. It is not perfect and it is not the long-term solution. However, it does, in our view, meet the three critical tests I outlined to you today and would provide meaningful benefits, effectively and safely to those seniors with the greatest need.

This program is designed as an interim, or stopgap approach. By providing federal assistance to states that voluntarily elect to develop prescription assistance programs, SenioRx Gold builds upon the 15 states that already have been successfully operating these programs. It gives the states the flexibility to meet the needs of 64 percent of those Medicare beneficiaries without prescription drug coverage. In fact, SenioRx Gold would provide a more comprehensive benefit than other proposals. With no premiums, no annual deductible and lower copays, needy seniors would not be deterred from participating.

Whichever course you pursue, we thank you for the opportunity to share our views and remain committed to working with you to address this and other issues.

Thank you very much.

Mr. MCCRERY. Thank you, Mr. Fuller.

Ms. Bello?

STATEMENT OF JUDITH H. BELLO, EXECUTIVE VICE PRESIDENT, POLICY AND STRATEGIC AFFAIRS, PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA

Ms. BELLO. I am pleased to be here this afternoon on behalf of Americas innovative pharmaceutical industry to discuss an issue vitally important to all of us, prescription drug coverage for elderly and disabled Americans.

In the nineties, we developed 370 new medicines for patients. Today, we have over 1,000 medicines in development to treat hundreds of serious illnesses such as Alzheimer's, Parkinson's, cancer, arthritis and depression. The 21st century hailed as the golden era of biology brings even greater promise. As the mapping of the human genome nears completion, our targets for drug innovation will be multiplied six to twenty times over from about 500 drug targets today to 3,000 to 10,000 in the near future.

We want to ensure that America's seniors have access to the medicines we have already developed without discouraging the discovery and development of many more medicines for all patients. I hope we all can agree on at least four points.

First, expanded drug coverage for seniors will happen. If we work together, it can happen in this Congress.

Second, expanded drug coverage for seniors will be a positive development. We all care so much about the subject of today's hear-

ing because many prescription drugs increasingly are the most effective therapy for many patients and the most cost effective therapy for the Medicare Program in our society.

For example, when a senior named Francis Wagner suffered a stroke, his doctor prescribed an innovative clot-busting medicine. Thanks to his medicine only 12 days later he was dancing with his wife on their 50th wedding anniversary celebration. An NIH study demonstrates that Medicare saved on average over $4,000 by treating Mr. Wagner with the medicine which reduced his hospital and rehabilitation bills and also avoided his admission to a nursing home.

Third, as we expand drug coverage for seniors, we must sustain the industry's ability to develop new medicines for all patients and their families.

Finally, we need to put the interest of patients first and to help both Medicare patients who need access today to medicines already developed and patients of all ages and their families who depend on the industry because they need new medicines and hopefully cures not yet developed.

Since February 1999, we have strongly supported strengthening and modernizing Medicare, including expanded coverage of prescription drugs. We support the views expressed by Mr. Thomas and Senator Breaux amongst others this morning that the current program needs to be preserved and strengthened.

As we also heard from both sides of the aisle, the Congress is now pursuing interim expansion of drug coverage through private insurance using choice and competition to ensure quality and contained costs. PhRMA can support an incremental approach if it would improve opportunities for future comprehensive reform and meet the following key principles: Give all beneficiaries the voluntary ability to enroll in a private insurance coverage plan of their choice among a range of operations; provide Federal subsidies for the low income beneficiaries so they can afford coverage; provide coverage for beneficiaries with high pharmaceutical expenditures; give beneficiaries access to all medicines; provide for oversight of plans by a new government entity; ensure that the new program would be consistent with needed comprehensive modernization of the Medicare Program; and offer coverage through competing, private insurance plans that rely on marketplace competition to improve quality and contain costs.

Government price controls, in our view, are unacceptable because they would inevitably harm the industry's ability to develop new medicines for all patients.

Finally, some skeptics voice concerns about adverse selection and claim that a private insurance program cannot work. We have consulted with experts, actuaries and also economic firms who have advised us that adverse selection is an important challenge in any private insurance product involving individual choice but that if a program is properly designed, it can work.

They recommend the following tools to minimize the impact of adverse selection, including limiting election opportunities for enrollment, providing low income subsidies for premiums and deductibles, establishing a high risk pool for enrollees with very high expenditures, requiring up front cost sharing such as an an-

nual deductible and also allowing insurers to negotiate with manufacturers and distribution networks to reduce costs.

In conclusion, the industry supports expanded drug coverage for seniors and disabled Americans done the right way. The pharmaceutical industry remains committed to finding a bipartisan solution that will help seniors have access to the medicines they need while also allowing thousands of our dedicated scientists to continue the search for new medicines and hopefully cures to help all patients and their families.

Thank you.

[The prepared statement follows:]

Statement of Judith H. Bello, Executive Vice President, Policy and Strategic Affairs, Pharmaceutical Research and Manufacturers of America

INTRODUCTION

Mr. Chairman and Members of the Committee, I'm pleased to be here on behalf of America's innovative pharmaceutical industry to discuss an issue that is vitally important to all of us—prescription drug coverage for seniors and disabled citizens. Across America, 40,000 scientists in our research labs work day and night in hopes of finding the next cure or the next treatment to allow individuals to live long, healthy, and productive lives (see Attachment 1). On average, it takes 12 to 15 years and $500 million to develop a new drug and bring it to market.

Today, industry has more than 1,000 new medicines in development to treat hundreds of serious illnesses including Alzheimer's and Parkinson's diseases, cancer, stroke, arthritis, and depression. We are confident that, in time, we will find the cures for these and other conditions that are so prevalent among our aging population (see Attachment 2).

The 21st century brings even greater promise. As the human genome is mapped, many new targets for pharmaceutical innovation will be identified. Today's 500 or so targets for drug interventions are expected to increase to 3,000 to 10,000 targets in the near future. When these treatments and hopefully cures are brought to market, we want to ensure that seniors have access to them—without discouraging the discovery and development of new medicines.

In our discussions, I hope that we all can begin by agreeing on at least four key points:

First, expanded drug coverage for seniors *will* **happen.** The question is not whether it will happen, but when, how, and with what effects on the quality of health care for seniors and disabled Americans and on drug discovery and development. If we work together, it could happen in this Congress. Most Medicare beneficiaries have prescription drug coverage through their (or their spouse's) current or former employer, a Medicare supplemental insurance (or Medigap) policy or a Medicare+Choice plan, or by qualifying for Medicaid or other governmental programs. But many of those who do not have the coverage they need require additional assistance. The pharmaceutical industry wants to be part of a sound, market-based solution that will help all patients today and into the future.

Second, expanded drug coverage for seniors will be a positive development. Prescription drugs are increasingly the most effective and cost-effective therapy with which to treat diseases or conditions. Some Medicare beneficiaries are in need of prescription drug coverage and our medicines provide extraordinary value to them.

Third, as we expand drug coverage for seniors, we must sustain the American pharmaceutical industry's worldwide leadership. The industry has developed new medicines that benefit *all* patients—young and old—and their families. We do not want to harm the environment in the U.S. that has allowed our industry to thrive. In the1990s alone, 370 prescription drugs, biologics, and vaccines developed by industry were approved for patients' use with a physician's prescription. Almost half of the globally important new medicines in the world are discovered by the U.S. industry (see Attachment 3). We are the world's leader in pharmaceutical research and development (see Attachment 4).

As we work together to expand access to prescription drug coverage, we must remember that Medicare beneficiaries want access to new medicines *because they were invented*

Finally, we need to always remember to put the interests of patients first. In an environment where we discuss 10-year forecasts, adverse selection, risk pools,

and premium calculations, we must not forget that the real focus is on patients. Our goal should be to expand Medicare drug coverage in the way best for patients, their children, and their grandchildren—who need access today to medicines already developed, and who also depend on the pharmaceutical industry to continue to lead the way in developing new medicines and hopefully cures that exist today only in our dreams.S6631

THE PHARMACEUTICAL INDUSTRY SUPPORTS EXPANDED PRESCRIPTION DRUG COVERAGE FOR ELDERLY AND DISABLED AMERICANS

Since February 1999, the pharmaceutical industry has strongly supported strengthening and modernizing Medicare, including expanding Medicare coverage of prescription medicines (see Attachment 5). We believe that the best way to expand prescription drug coverage for Medicare beneficiaries is through comprehensive Medicare reform. The current program is based on a 1960s-style, one-size-fits-all model that relies on centralized price controls and complex regulations. The result is a program that is confusing for patients and providers, difficult to administer, and inadequate to meet the health care needs of the 21st century.

If the Congress decides to pursue instead interim expansion of drug coverage through private-sector insurance (using choice and competition to ensure quality and contain costs), PhRMA can be supportive so long as the interim measures would improve, rather than impede, opportunities for future comprehensive reform (see attachment 6).

With respect to the delivery system for any proposal, law and policy makers need to ask:

- Should the drug benefit be delivered by the government or the private sector?
- Should the benefit be a single, one-size-fits-all program, or should seniors and disabled beneficiaries have a range of choices?

We believe several principles are key components of any interim proposal. As Congress continues to grapple with this complex issue, we will support proposals consistent with these key principles:

- All beneficiaries would have the ability to enroll in a private insurance coverage plan of their choosing, ranging from private fee-for-service to HMOs and various private-sector options in between.
- Federal subsidies would help low-income beneficiaries afford coverage.
- Plans would provide coverage for beneficiaries with high pharmaceutical expenditures.
- Beneficiaries would have access to all medicines.
- Plans should be overseen by a new government entity.
- The new program would be consistent with, and a step toward, needed comprehensive modernization of the Medicare program.
- Coverage would be offered through competing, private insurance or health plans that rely on marketplace competition to control costs and improve quality.

Government price controls are unacceptable because they would inevitably harm the industry's ability to develop new medicines for patients. We urge you to say "no" to price controls in any form, not direct price controls, not indirect price controls, not by design, not by accident, not by stealth, not by baby steps.

A PRIVATE INSURANCE INCREMENTAL APPROACH WILL BEST SERVE PATIENTS TODAY AND TOMORROW

The pharmaceutical industry believes that if Congress decides to provide an incremental prescription drug benefit, the best approach would be to provide seniors access to private insurance products. This approach would fit easily into the current marketplace, since well over 150 million people get their drug coverage through private entities. In delivering drug coverage, these private entities would do more than simply pay the claims. They could provide disease management programs, drug utilization review, patient education, and help to reduce medical errors. We in the research-based pharmaceutical industry believe that seniors and disabled beneficiaries would benefit greatly by having access to these private insurance products, with the government providing subsidies for those in need.

Skeptics point to complex issues, such as "adverse selection," and claim that a private insurance program will not work. Adverse selection can occur because individuals purchase insurance only when it is in their best interest. If an individual could purchase insurance at *any* time, it would be perfectly rational for them to wait until

they were sick. Consequently, insurers often place limits on when individuals can purchase insurance and under what conditions.

Recognizing that adverse selection is an important issue, we asked the experts for assistance. We turned to leading actuarial and economic firms including Milliman and Robertson, Abt Associates, and Towers-Perrin and commissioned analyses (see Attachments 7, 8, and 9). These actuaries and economists note that a private prescription drug insurance program can work if designed properly. They also note that adverse selection is "one of the most difficult issues in designing *any* insurance program involving individual choice." Actuaries and economists have several tools to minimize the impact on adverse selection. These include:

- Limiting election opportunities for enrollment;
- Providing low-income subsidies for premiums and deductibles;
- Establishing a high-risk pool for enrollees with very high expenditures;
- Requiring up-front cost sharing, such as an annual deductible; and
- Allowing insurers to negotiate with manufacturers and distribution networks to reduce costs.

We believe that a properly designed prescription drug insurance benefit would attract many Medicare purchasers and many private market sellers. Why are we so confident? In the market today, there are private *health* insurance policies for cancer, sports accidents, emergency room visits, pregnancy complications, and campers. There are private insurance products for goats, carriage rides, and the weather on the day of your daughter's wedding (see Attachment 10). We believe that there are similar opportunities for private-market solutions to increase access to prescription drug coverage for the elderly and disabled Americans.

CONCLUSION

In my testimony today, I've tried to highlight the pharmaceutical industry's support for expanded drug coverage for seniors and disabled Americans—done the *correct* way.

Some say that this issue is life or death for the pharmaceutical industry, America's premier high-technology industry. After the debate is over and the dust settles, we will still have a pharmaceutical industry—but depending on what you do, the industry could be profoundly different, and the results for patients could be demonstrably less.

As the debate unfolds, I hope you'll remember the millions of Americans and their families waiting impatiently for new treatments and hopefully cures. We can provide quality health care for seniors and the disabled, including better prescription drug coverage, but we need to do it the *correct* way. If we do it the *wrong* way, the industry and the patients we serve will undoubtedly suffer the consequences.

ATTACHMENT 1

THE RESEARCH-BASED PHARMACEUTICAL INDUSTRY: FACTS AT A GLANCE

A Strong Commitment to Research and Development

- This year, research-based pharmaceutical companies will invest $26.4 billion in research and development (R&D) on innovative new medicines. This represents an increase of 10.1 percent over research spending in 1999. Since 1980, research-based companies have multiplied their R&D investment 13-fold.
- Domestic R&D is expected to increase by nearly 12 percent in 2000.
- R&D conducted abroad by U.S. based companies will grow only 1.2 percent—a clear sign that the American system nurtures innovation and discovery.
- Over the past two decades, the percentage of sales allocated to pharmaceutical R&D has increased from 11.9 percent in 1980 to approximately 20.3 percent in 2000, higher than virtually any other industry. The average for all U.S. industries is less than four percent.
- Approximately 36 percent of pharmaceutical R&D conducted by companies worldwide is performed in the United States, followed by Japan with 19 percent.
- This U.S. industry investment is very efficient. Of 152 major global drugs developed between 1975 and 1994, 45 percent are of U.S. origin.

Drug Discovery and Development Are High-Risk

- During the 1990s, the average time it took to discover, test and develop a single new drug increased to nearly 15 years. This was almost twice the development time in the 1960s.
- Of every 5,000–10,000 compounds tested, only five enter human clinical trials, and only one is approved by the FDA for sale in the U.S. Of every 10 medicines in the market, on average, only three generate revenues that meet or exceed average R&D costs.

• The Boston Consulting Group estimates that the pre-tax cost of developing a drug introduced in 1990 was $500 million, including the cost of research failures, the opportunity cost of capital over the period of investment, and the increasing cost of clinical trials.

Medicines in Development

• The research-based pharmaceutical industry currently has more than 1,000 new medicines in development to treat hundreds of serious diseases.

• There are currently 369 biotech medicines in the pipeline to combat over 200 diseases. Nearly half the medicines −175—are for cancer, the second leading killer of Americans. Biotechnology and new technological tools have revolutionized cancer research.

• Among these drugs and biologics in development are promising new treatments for cancer, heart disease, Alzheimer's, AIDS, diabetes, multiple sclerosis, Parkinson's, stroke, rheumatoid arthritis, and depression.

The Value of Medicines

• The estimated life expectancy of an American born in 1920 was 54 years. By 1965, life expectancy had increased to 70 years. The average American born today can expect to live more than 76 years, and life expectancy has risen dramatically for all age groups. Every five years since 1965, roughly one additional year has been added to life expectancy at birth. These improvements in life expectancy are due to advances in medicine and our improved ability to prevent and treat disease:

• Antibiotics and vaccines have virtually wiped out such diseases as diptheria, syphilis, whooping cough, measles and polio in the U.S.

• The influenza epidemic of 1918 killed more people than all the battles fought during the First World War. Since that time, medicines have helped reduce the combined U.S. death rate from influenza and pneumonia by 85 percent.

• Over the past 30 years, innovative medicines have helped reduce deaths from heart disease and stroke by half, enabling 4 million Americans to live longer, better lives.

• Since 1965, drugs have helped cut emphysema deaths by 57 percent and ulcer deaths by 72 percent.

• In a year-long disease-management program for about 1,100 patients with congestive heart failure run by Humana Hospitals, pharmacy costs increased by 60 percent, while hospital costs (the largest component of U.S. health care spending) declined 78 percent. The net savings were $9.3 million.

• A National Institutes of Health (NIH) study showed that while it initially costs more to treat stroke patients with a clot-busting drug, the expense is more than offset by reduced hospital rehabilitation and nursing home costs. Treatment with the clot-buster costs an additional $1,700 per patient, but reduced hospital rehabilitation and nursing home costs result in net savings of more than $4,000 per patient.

• According to a study published in the *New England Journal of Medicine,* the use of ACE inhibitor drugs for patients with congestive heart failure reduced mortality by 16 percent, avoiding $9,000 in hospital costs per patient over a three-year period. Considering the numbers of people at risk for congestive heart failure, additional use of ACE inhibitors could potentially save $2 billion annually.

• According to a study conducted at the University of Maryland Medical Center, patients treated with beta-blockers following a heart attack were up to 40 percent less likely to die in the two-year period following the heart attack than the patients that did not receive the drugs. According to another study, use of beta-blockers resulted in an annual cost savings of up to $3 billion in preventing second heart attacks and up to $237 million in treating angina.

• Unfortunately, a study published in the Journal of the American Medical Association found that only half the people who could be helped by these medicines are getting them.

• Estrogen-replacement therapy can help aging women avoid osteoporosis and crippling hip fractures, a major cause of nursing home admissions. Estrogen-replacement therapy costs approximately $3,000 for 15 years of treatment, while a hip fracture costs an estimated $41,000.

• The combination of two drugs, at a cost of about $140 can eradicate the bacterial cause of most ulcers. Ulcer surgery costs upward of $28,000.

Attachment 2

Prevalence, Cost, and Medicines in Development for Selected Major Diseases in the United States

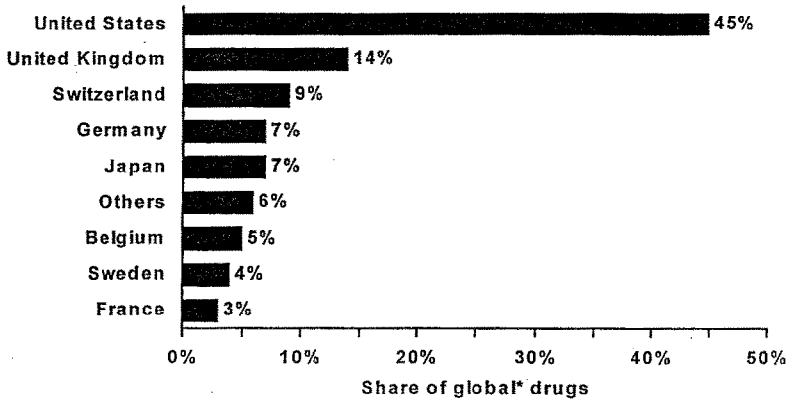
Uncured Disease	Approximate Prevalence	Approximate Annual Economic Cost ($billions)	Number of Medicines in Development*	Source
Alzheimer's Disease	4,000,000	$100.0	23	National Institute on Aging
Arthritis	40,000,000	$54.6	28	Arthritis Foundation
Asthma	14,000,000	$6.2	17	National Heart Lung and Blood Institute
Cancer	8,000,000	$107.0	316	American Cancer Society
Congestive Heart Failure	4,900,000	$20.2	17	American Heart Association
Coronary Heart Disease	13,900,000	$95.6	38	American Heart Association
Depression	17,600,000	$53.0	17	National Institute on Mental Health
Diabetes	15,700,000	$98.2	19	National Institute of Diabetes
Hypertensive Disease	50,000,000	$31.7	10	American Heart Association
Osteoporosis	10,000,000	$13.8	24	National Osteoporosis Foundation
Schizophrenia	1,500,000	$23.0	12	National Institute of Mental Health
Stroke	4,000,000	$43.3	22	American Heart Association

*PhRMA data.

Source: Compiled by PhRMA, 2000.

Attachment 3

Development of 152 Global* Drugs by Country of Origin, 1975–1994

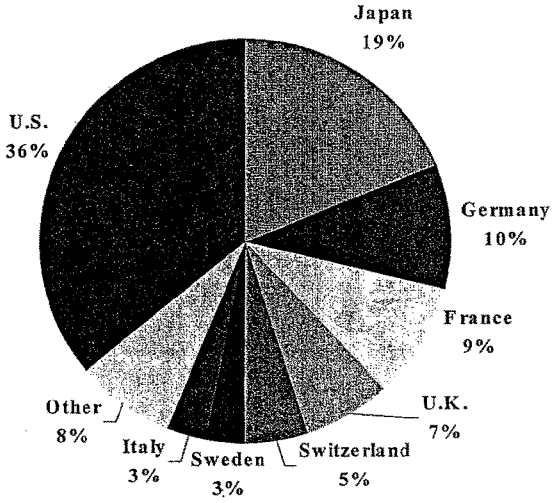


Global drugs: Launched in U.S., Japan, France, Germany, U.K., Italy and Switzerland.

Source: Barral, P.E., 20 Years of Pharmaceutical Research Results Throughout the World, Rhone-Poulenc Rorer Foundation, 1996.

Attachment 4 (Part 1)

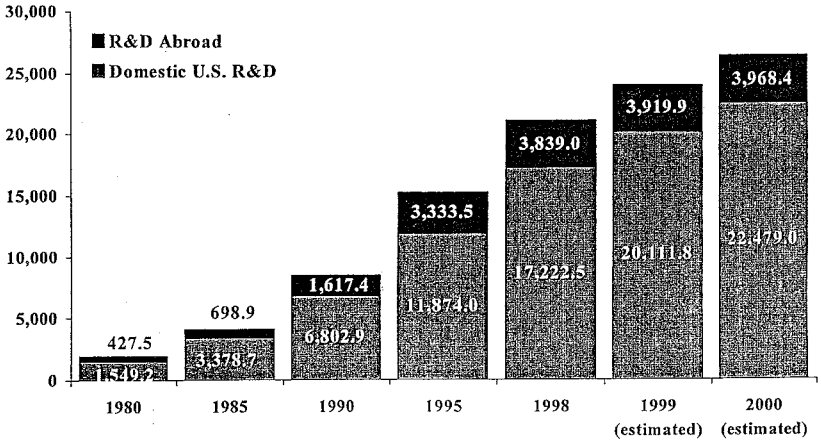
Company-Financed Pharmaceutical Research & Development by Location, 1997



Source: Centre for Medicines Research, U.K., 1999.

Attachment 4 (Part 2)

R&D Expenditures, Research-Based Pharmaceutical Companies 1980-2000



Source: PhRMA Annual Survey, 2000.

PhRMA Medicare Prescription Drug Position

The Pharmaceutical Research and Manufacturers of America (PhRMA) supports pharmaceutical coverage for Medicare beneficiaries. We believe that the best way to provide pharmaceutical coverage to Medicare beneficiaries is through comprehensive modernization of the Medicare program to provide beneficiaries a choice of health plans that would also provide drug coverage. If such modernization does not occur this year, PhRMA would support federal legislation that would provide all seniors with access to pharmaceutical insurance coverage, wherever they live and no matter how sick they are.

Such a proposal would have the following elements:

1.All beneficiaries would have the ability to enroll in any qualified pharmaceutical coverage plan of their choosing.

2. Federal government subsidies would help low-income beneficiaries afford coverage.

3. Each beneficiary would be offered a choice of multiple competing, private insurance plans that rely on marketplace competition to control costs and improve quality.

4. Plans would provide coverage for beneficiaries with high pharmaceutical expenditures.

5. Beneficiaries would have access to all medicines.

6. Plans would be overseen by a new, independent government entity.

7. This new program would be consistent with, and step toward, needed comprehensive modernization of the Medicare program.

Several existing proposals embody these elements in whole or part. We offer our assistance and support in advancing the goal of enhanced pharmaceutical coverage this year.

ATTACHMENT 10

TYPES OF INSURANCE

There are many varying types of insurance coverage available in the United States. Coverage can range from the typical health and auto insurance, to the more unusual, including insurance for a dancer's legs or a doctor's hands. If a client is willing to pay, there are few limits to the types of insurance coverage available.

Listed below are a number of insurance products ranging from health to weather conditions.

Health Insurance

- Critical Illness Insurance
  Cancer, heart disease, etc.
- Critical Security Insurance
  For those suffering from a critical illness
- Children's Insurance
- College Students' Health Insurance
- Emergency Room Insurance
- Catastrophic Disability Insurance
- Infertility Coverage
- Pregnancy Complication Insurance
- Hospital Indemnity Insurance
  Covers hospital confinement and ICU
- Campers Accident & Sickness Insurance
- "Specified Diseases" Insurance
  E.G. stroke, diabetes, HIV
- Pre-Schooler Accident Insurance
- Sports Accident Insurance
- Psychiatric Insurance
- "Natural Health Supplemental Insurance"
  Covers acupuncture, homeopathy, Oriental medicine, nutritional counseling, biofeedback, colon therapy, etc.

Horse Related Insurance

- All Breeds
  National and International)/All Disciplines
- Animal Mortality*
  National and International
  (Horses, Mules, Donkeys, Dogs, Ostrich, Sheep, Pigs, Goats, Llamas, Exotics, to name a few.)
- Associations
- Auto
- Barns
- Barrel Racing
- Bed and Breakfasts (Inns)
- Blacksmiths
- Boarding
- Boats
- Breeding
- Business Packages
- Care, Custody and Control
- Carriage Rides
- Clinics
- Combined Training
- Commercial Farm Auto
- Commercial Horse Liability
- Commercial Packages
- Cutting
- Dairy Farms
- Draft Horses
- Dressage
- Drill Teams
- Driving
- Dude Ranches
- English
- Equine Dentists
- Equitation
- Eventing
- Farm Machinery
- Farms
- Farriers
- Flood
- Fox Hunters

ATTACHMENT 10

TYPES OF INSURANCE

- Gaited Horses
- Gymkhanas
- Harness Horses
- Hay Rides
- Horse Haulers
- Horse Owners
  Private Liability
- Horse Shows
- Horse Trailers and Vans
- Hunters
- Instructors Liability
- Jumping Horses
- Leased Horses
- Liability, Commercial and Personal
- Livestock
- Major Medical
- Marinas
- Miniature Horses
- Mounted Troops
- Orchards
- Personal Auto
- Personal Liability
- Personal Umbrella
- Pleasure Animals
- Ponies
- Pony Party Liability
- Race Horses
- Race Horse Liability
- Reining Horses
- Restaurants and Taverns
- Riding Lessons
- Riding Stables - Public and Private
- Roping
- Saddle Shops
- Saddleseat
- Sales Barns
- Shipping
  Both International and National
- Sleigh Rides
- Sport Horses
- Sports Accident Coverage
- Stables
  Public and Private
- Steeplechasers
- Stock Horses
- Student Accident Coverage
- Tack Shops
- Tack and Equipment
- Team Penning
- Three Day Eventing
- Trail Rides
- Trailers
- Transport
  National and International
- Trotters
- Truckers
- Truckers General Liability
- Vans
- Vaulting
- Vet Clinics
- Veterinarians
- Vineyards
- Workers Compensation

Weather Insurance

(covering hurricane, typhoon, rain, snow, wind, hail, etc.)

- ***Special Events***: Fairs, Festivals, Airshows, Fourth of July, Chambers of Commerce, Parties, Weddings, Fireworks, Parades, Fundraisers, Company Outings, Conventions, Carnivals, Picnics, Hospitality, Theatrical Productions
- ***Concerts***: Amphitheater, Promoters, Venues, Concessions, Sheds/Shacks
- ***Sports***: Racing, Football, Baseball, Mud Racing, Basketball, etc.
- ***Entertainment***: Commercials, TV Shows, Film/Video Productions, Photo Shoots, Advertising
- ***Promotions***: Car Dealers, Jewelry Stores, etc.

ATTACHMENT 10

TYPES OF INSURANCE

- ***Agricultural***: Fruit/Vegetable growers, Packers, Canneries, Juicers, etc.
- ***Snow Removal***: Municipal, Towns, School Districts, Airports, Universities, etc.
- ***Weather Sensitive Business***: Resorts, Country Clubs, Florists, Ski Resorts, Utilities, Flea Markets, etc.

Marine Insurance

- Private Pleasure Craft
- Boat Dealers
- Piers, Wharves, and Docks
- Charterers Legal Liability
- Marina Operators
- Passenger Vessels

[Attachments 5, 7, 8, and 9 are being retained in the Committee files.]

Mr. MCCRERY. Thank you, Ms. Bello.

Ms. Briceland-Betts?

STATEMENT OF DEBORAH BRICELAND-BETTS, J.D., EXECUTIVE DIRECTOR, OLDER WOMEN'S LEAGUE

Ms. BRICELAND-BETTS. Thank you. I appreciate your invitation to testify today. I commend you and the Committee for engaging in the important discussion of updating and strengthening Medicare for the 21st century.

I can assure you that our members care deeply about this issue. It is because women are quite literally the face of Medicare. They are the majority of beneficiaries at every age level and because of their longer lives, they have more chronic illness and take more prescription drugs.

Women must purchase those medications from a retirement income that averages 40 percent of men's retirement income. I want to be clear here today access to prescription drugs is not simply a problem for the poor. After premium payments, prescription drugs

account for the single largest component of out of pocket spending for noninstitutionalized Medicare beneficiaries aged 65 and older. Consequently, many seniors with moderate incomes are also finding the high cost of prescription drugs to be out of their reach. Many of them, as we have heard today, are sacrificing their future financial security and sadly, even playing a game of russian roulette with their health as a result.

Stories abound of seniors trying to stretch their medications by not taking required dosages and in fact, some are just not taking their needed medications at all. OWL strongly believes that the prescription drug coverage for seniors is needed to modernize and strengthen Medicare. Further, such a program is best implemented through a defined benefit package that is voluntary, comprehensive and universally available to all Medicare beneficiaries.

Co-payments, premiums and deductibles must be affordable and benefits should be indexed to inflation to ensure that coverage keeps pace with the cost of prescription drugs.

Last, adequate stop loss protections and catastrophic coverage are critical components and measures must be taken to ensure that a new prescription drug benefit does not put current Medicare benefits at risk.

Both President Clinton and the Republican leadership have put forward plans that address this critical public health issue, so allow me to make a few comments in that direction.

While OWL does not endorse legislation, we can provide a unique age and gender analysis that I hope you will find helpful. OWL is pleased that the Republican leadership is taking an active interest in providing affordable prescription drugs for this Nation's seniors. We are glad to see the 100 percent subsidy for beneficiaries with incomes under 135 percent of poverty with an additional safety net in the form of a sliding fee scale for assistance to those between 135 and 150 percent of poverty.

Despite this bright spot, and in light of the principles I outlined earlier, I must admit that we have larger concerns about the proposed plans' ability to provide meaningful coverage for all older Americans. OWL was disappointed to see that the Republican plan or what we know of it does not represent a defined benefit added to the Medicare Program, but rather, a private insurance option.

We are concerned that the Medigap type plans being proposed with insurers getting a subsidy to lower the premiums will not be affordable for most seniors even in the unlikely event that an insurer passed on every dollar and subsidy to the beneficiary.

Further, the notion of permitting insurers to offer a standardized benefit or its actuarial equivalent may cause adverse selection problems and could further erode the benefit. Given that many insurers will probably not offer a standalone prescription drug policy in light of the relatively small subsidy, OWL was interested to note that the plan provides for a Medicare-run policy for areas where private options don't exist. I suspect this option will actually represent the bulk of the coverage if the plan were enacted. If so, why not just create a defined benefit within the Medicare Program right from the start?

OWL is also extremely concerned that the private plans will be quite restrictive in their application of formularies. This would be

especially troubling for the older women who more often require the higher end, cutting edge drugs to treat their chronic illnesses.

OWL is also worried that the plan apparently only pays for 50 percent of the beneficiary's drug costs after a deductible requirement is met. Given the financial constraints of many older women, 50 percent copayments could well be out of reach. Frankly, this is a concern that OWL has with both the Republican and Democratic plans. We must remember that the median income for women over 65, the majority of Medicare beneficiaries, is $14,820. This figure is above the magic bullet of 150 percent of poverty and is by no means a healthy income. A 50 percent copay is quite likely to be out of reach. Realistically, someone who cannot afford a $250 prescription will probably still struggle to afford a $125 prescription.

Affordability also goes to premiums. We have been told that the Republican plan will average about $37 a month but it could vary widely by plan and region. Again, with the economic constraint of the majority of Medicare recipients, this becomes a critical factor.

OWL would also like to see both plans firm up their catastrophic coverage.

In conclusion, with the respective legislative plans aside, I must also say whatever prescription drug coverage is discussed, we must acknowledge that we are here today because America's seniors cannot afford the high cost of prescription drugs. We have yet to hear an adequate explanation as to why, for instance, from 1980 to 1998, the Consumer Price Index rose 98 percent, prescription drugs rose 256 percent or why the pharmaceutical industry continues to lead the Fortune 500 in profits.

OWL has been advocating for prescription drug coverage in Medicare for 20 years but we are not so anxious that we feel Congress should rush the process. We need a bipartisan plan that works for America's seniors, one that provides meaningful cover for people, not one that just provides political cover.

We look forward to working with Congress and the administration to assure whatever measures are finally adopted, truly work for older people.

Thank you.

[The prepared statement follows:]

Statement of Deborah Briceland-Betts, J.D., Executive Director, Older Women's League

Mr. Chairman and distinguished Members of the Committee:

I appreciate your invitation to testify today on the timely issue of developing a prescription drug benefit for Medicare. OWL commends you and the Committee for engaging in the important discussion of updating and strengthening Medicare for the 21st century.

As the Executive Director of OWL, the only national grassroots membership organization dedicated exclusively to the unique concerns of women as they age, I can assure you that our members are fired up about this issue. Many of the healthcare hurdles facing older women have not changed since OWL's 1999 Mother's Day Report, **The Face of Medicare is a Woman You Know,** and its addendum **Medicare: Why Women Care** were published. And just last month, OWL released its first Mother's Day Report of the new millennium, **Prescription for Change: Why Women Need a Medicare Drug Benefit.** Based on this research and the longtime leadership of OWL on this issue, I am pleased to share with you some concrete suggestions that both would modernize Medicare and truly help those who use the Medicare program the most: older women.

Women are quite literally the face of Medicare. Let me paint you a picture of the typical Medicare recipient:

• She is 58% of the Medicare population at age 65 and 71% at age 85; as you know, the fastest growing portion of our population is age 85 plus;
• She is managing more than one chronic illness at a time. At age 65, 9 in 10 women have at least one chronic illness; 73% have two or more chronic illnesses;
• She has outlived her spouse, she's divorced or, increasingly, she's never been married; and because she's alone, she is five times more likely to be poor; older women are 75% of the elderly poor;
• and she is paying an average of 20% of her annual income for out-of-pocket health expenses such as prescription drugs and supplemental health insurance. This compares to 17% for male Medicare recipients.

And though she may be living in her own home today, her poor health and the lack of help in managing her daily affairs will probably require her to seek long-term care—paid for by Medicaid—tomorrow.

Because older women are more likely to be poor, they are more likely to face financial barriers to health care and thus spend a greater portion of their income on such costs. Except for those individuals enrolled in managed care programs, Medicare does not cover prescription drugs unless they are used in a hospital or other health care institution. Yet almost eight of ten women on Medicare—that's 17 million women—use prescription drugs regularly, and thus many pay for these medications out-of-pocket.[1] All told, because of our greater longevity and tendency towards more chronic illnesses, women on Medicare spend 20% more on prescription drugs than their male counterparts.[2]

We must remember that this financial burden is being placed on women who are, at every age, at a greater risk for poverty than their male counterparts. These disparities are particularly pronounced in old age. Women's retirement income is almost less than half of men's. More than half of women age 65 and over have personal incomes of less than $10,000 a year, and three out of four have incomes under $15,000.[3] Research shows that beneficiaries with high or very high out-of-pocket drug costs are those with modest incomes. One recent study found that beneficiaries with the highest average out-of-pocket drug expenses are those with incomes between 135 and 200 percent of poverty.[4]

But I want to be clear here today. Access to prescriptions drugs is not simply a problem for the poor. While older Americans comprise only 13 percent of the U.S. population, they account for one-third of all prescription drug spending.[5] In fact, after premium payments, prescription drugs account for the single largest component of out-of-pocket spending for non-institutionalized Medicare beneficiaries' age 65 and older.[6] Consequently, many seniors with moderate incomes are also finding the high cost of prescription drugs to be out of their reach; many of them are sacrificing their future financial security and, sadly, even playing a game of Russian roulette with their health as a result. Stories abound of seniors trying to stretch their medications by not taking the required dosages, and in fact some are not taking needed medicines at all.

A new international health care survey of the elderly by the Commonwealth Fund reported 7% of adults ages 65 and over did not even fill a prescription.[7] Why? Because they can't afford them, and there is no comprehensive benefit that provides the medicines they need at a reasonable cost. We even hear of how this financial burden is trickling down through the generations, with working families paying for parents' prescriptions and thus limiting what they can save for their children's education or their own retirement. So I must stress that these catch-22 decisions are not limited to the poor. Middle-income seniors are finding their retirement security undermined by the high cost of prescription drugs. The barriers are very real, and a simple Medicaid enhancement will therefore not solve the full scope of the problem.

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[1] Kaiser Family Foundation/Commonwealth Fund, Survey of Medicare Recipients.
[2] National Economic Council, Domestic Policy Council, *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage,* July 22, 1999.
[3] Stone and Griffith, *Older Women: The Economics of Aging, Women's Research & Education Institute,* 1998
[4] Gibson and Brangan, *Out-of-Pocket Spending on Health Care by Women Age 65 and Over in Fee-for-Service Medicare: 1998 Projections,* AARP Public Policy Institute, 1998.
[5] Statement of Beatrice Braun, M.D., Testimony Before the Subcommittee on Health of the House Committee on Ways and Means Hearing on Senior's Access to Prescription Drug Benefits, February 15, 2000.
[6] Statement of Beatrice Braun, M.D., Testimony Before the Subcommittee on Health of the House Committee on Ways and Means Hearing on Senior's Access to Prescription Drug Benefits, February 15, 2000.
[7] Commonwealth Fund

In fact, limiting a Medicare drug benefit to only those with low incomes would exclude many of the people most in need of assistance, including those with modest incomes (135–200% of poverty). Research suggests that beneficiaries at all income levels experience high or very high drug spending and out-of-pocket costs.[8] Another study found that fully half of women on Medicare without any drug coverage at all have incomes above 150 percent of poverty.[9] A means tested program would also exclude those in poor and fair health, or with severe functional limitations, who have incomes or assets too high to qualify for Medicaid coverage. Clearly, then, this is as much an affordability issue as it is a coverage issue. That's why its important to design a program that provides all beneficiaries with access to an affordable prescription drug benefit.

Ironically, Americans who pay for all or part of their prescriptions out-of-pocket are charged far more than either insurance companies or HMOs. In fact, uninsured seniors often pay twice as much for their prescription drugs than more favored customers, such as those in big HMO plans or the federal government.[10] And those costs are rising. From 1981 to 1999, prescription drug prices increased by 306%, while the Consumer Price Index, on which Social Security's cost-of-living-adjustments are based, rose 99%.[11] Given this lopsided increase, we should not be surprised that the high cost of many prescription drugs are out of reach for many seniors, regardless of income.

This is a universal problem that requires a universal solution. Outpatient prescription drug coverage is one of the last major benefits still excluded form Medicare, and the elderly are the last major insured consumer group without access to prescription drugs as a standard benefit. With the technological revolution that is taking place in the development of safe and effective drug therapies, the absence of such a benefit is a critical barrier to providing comprehensive, effective treatment to our rapidly aging population. And, quite frankly, a prescription drug benefit is logical. Medicare was designed to cover the medical costs for seniors—and prescription drugs are the name of the game in 21st century medicine.

In some cases, prescription drugs can be a substitute for surgery; in others, it can postpone institutionalization. Yet one in eight seniors cannot afford the cost of prescription drugs.[12] Those individuals not only put their health at risk, but also ultimately cost the Medicare system more in costs for additional treatments and hospitalizations that might have been avoided through proper medication.

It's also obvious that existing approaches to this issue are not enough. Medigap coverage is limited and spotty, HMO coverage is decreasing and often unreliable, and employer-sponsored coverage is just plain declining. One in every three Americans over age 65 has no prescription drug insurance. Millions more have only limited coverage, which is slipping away as HMOs and company retirement plans cut back or drop altogether their drug benefits.[13]

Frankly, the existing coverage options are inadequate, limited, expensive, and unstable. For instance, a new study by the Commonwealth Fund reports that most Medicare beneficiaries do not have continuous prescription drug coverage. In 1996, just 53 percent of beneficiaries had prescription drug coverage *throughout* the year.[14] Thus, while low-income Americans would certainly benefit from a prescription drug benefit, targeting only low-income beneficiaries would leave millions of seniors without affordable, dependable coverage. Now is the time for a Medicare prescription drug benefit—OWL strongly believes that we must work to fix this particular roof while the sunshine of the surplus warms the debate.

Keeping in mind these pictures I've painted for you—both of the typical recipient and the scope of the problem—OWL would like to put forth several suggestions for your consideration as you deliberate the prospects for a Medicare prescription drug benefit package.

OWL strongly believes that prescription drug coverage for seniors is needed to modernize and strengthen Medicare. Further, such a program is best implemented through a defined benefit package that is voluntary, comprehensive, and universally available to all Medicare beneficiaries. Co-payments, premiums and deductibles must be affordable, and benefits should be indexed to inflation to ensure that cov-

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[8] AARP, "How Much are Medicare Beneficiaries Paying Out-of-Pocket for Prescription Drugs?" September 1999.

[9] Actuarial Research Corporation, unpublished data, 1999.

[10] Prescription Drug Task Force, US House of Representatives, October 28, 1999.

[11] Bureau of Labor Statistics, 1999.

[12] National Committee to Preserve Social Security and Medicare, "America's Quiet Crisis: Prescription Drug Costs for Seniors," 2000.

[13] National Committee to Preserve Social Security and Medicare, "America's Quiet Crisis: Prescription Drug Costs for Seniors," 2000.

[14] Commonwealth Fund, January 2000.

erage keeps pace with the cost of prescription drugs. Lastly, adequate stop-loss protections and catastrophic coverage are critical components, and measures must be taken to ensure that a new prescription drug benefit does not put current Medicare benefits at risk.

Let me briefly elaborate on each of these principles.

• The benefit should be part of the defined benefit package of a modernized Medicare program, and must be universally available to all Medicare beneficiaries, regardless of income. A means-tested program, or a simple expansion of Medicaid, will still leave millions of older Americans at risk.

• The benefit should be voluntary, allowing beneficiaries to keep their current coverage if they choose to do so. The plan should also consider incentives that will encourage those plans with retiree prescription coverage to maintain that benefit.

• The benefit needs to be affordable, with premiums, co-pays and deductibles that are within the reach of all seniors. This is an important element in avoiding the dangers of adverse risk selection. Also, the government contribution towards such a benefit must be sufficient to produce a premium and benefit design that is accessible to low income seniors.

• The benefit must assure access to medically appropriate drug therapies, including the high-end, cutting edge drugs that many older women need for common chronic illnesses. While we recognize that formularies are an important cost-cutting mechanism, alternatives must be in place to assure that beneficiaries have access to whatever prescription drugs most effectively treat their conditions.

• The benefit should be indexed to inflation to ensure that coverage keeps pace with the rising cost of prescription drugs. Further, drug purchasing strategies that enable the Medicare program to leverage of the purchasing power of the Medicare population should be explored.

Proposals to increase cost-sharing and deductibles under Medicare would likely discourage many women, for whom out-of-pocket health care expenses are already a hardship, from seeking the health care they need. Proposals to provide a set amount of money to purchase Medicare coverage—a voucher, if you will—would unfairly disadvantage women who could not afford the high cost of comprehensive coverage. Further, both approaches could lead to adverse risk selection within the plans, thereby inflating costs and endangering coverage. Frankly, if prescription drug coverage is available but not affordable, it just doesn't work. Medigap is an excellent example of this concept; it's available, but most people don't buy it because they can't pay the bill.

Both President Clinton and the Republican Leadership have put forward a plans to address this critical public health issue, so allow me make a few comments in that direction. While OWL does not endorse legislation, we can provide a unique age and gender analysis that I hope the subcommittee with find helpful.

OWL is pleased that the House Republican Leadership is taking an active interest in providing affordable prescription drugs for this nation's seniors. In looking at the Republican proposal, we are glad to see the 100% subsidy for beneficiaries with incomes under 135 percent of poverty, with an additional safety net in the form of a sliding fee scale for assistance to those between 135 and 150 percent of poverty. But despite this bright spot, and in light of the principles I outlined earlier, I must admit that we have larger concerns about the proposed plan's ability to provide meaningful coverage for all older Americans.

Based on the relatively few details we have seen of the Republican proposal, OWL was disappointed to see that the Republican plan does not represent a defined benefit added to the Medicare program, but rather a private insurance option. We are concerned that the Medigap-type plans being proposed, with insurers getting a subsidy to lower the premiums, will not be affordable for most seniors—even in the unlikely event that an insurer passed on every dollar in subsidy to the beneficiary. Further, the notion of permitting insurers to offer a standardized benefit or *its actuarial equivalent* may cause adverse selection problems that could further erode the benefit.

Given that many insurers will probably not offer a stand-alone prescription drug policy, in light of the relatively small subsidy, OWL was interested to note that the plan provides for a Medicare-run policy for areas where private options don't exist. I suspect this option will actually represent the bulk of the coverage if the plan were enacted—if so, why not just create a defined benefit within the Medicare program right from the get go?

OWL is also extremely concerned that private plans will be quite restrictive in their application of formularies. This could be especially troubling for older women, who more often require the high end, cutting edge drugs to treat their chronic conditions. Remember, women have more chronic conditions than men, and they live longer with those conditions.

OWL is also worried that the plan apparently only pays for 50 percent the beneficiaries' drug costs, after a deductible requirement is met. Given the financial constraints of many older women, 50 percent co-pays could well be out of reach. Frankly, this is concern that OWL has with both the Republican and Democratic plans. We must remember that the median income for women over 65—the majority of Medicare recipients—is $14,820.[15] This figure is above the magic bullet of 150% of poverty, but it is by no means a healthy income. A 50 percent co-pay is quite likely going to be out of reach—realistically, someone who cannot currently afford a $250 prescription will probably still struggle to afford a $125 prescription.

This affordability concern carries over into the areas of premiums. We have been told the Republican plan will average $37 per month—but it could vary widely by plan and region. Again, the economic constraints of the majority of Medicare recipients becomes a critical factor.

We note again that this is yet another area where a defined benefit, as part of Medicare, would be most appropriate—providing a consistency in premiums regardless of region, and stability in terms of coverage.

OWL would also like to see both plans firm up their catastrophic coverage. While we understand that the size of and start date for such coverage is very much dependent on the budget, an out-of-pocket cap in the neighborhood of $3000 seems reasonable. This protection would go a long way to ensuring that the retirement security of our country's seniors is not undermined by the skyrocketing costs of prescription drugs.

Let me illustrate OWL's concerns with the proposed plan by telling you the story of an OWL member. Diane Rudolph, 60, of Cleveland, OH, has worked hard to create a stable retirement for herself. She has an IRA, a small pension, and had arranged it so the mortgage on her home would be paid off when she retired at 65.

Diane never planned on a permanent disability, but that is exactly what happened. Chronic conditions such as diabetes, high blood pressure, and degenerative disc disease have been compounded by severe arthritis. In many ways Diane is fortunate; her COBRA insurance covers her many prescriptions for a manageable copayment, she has disability insurance, and has saved for her retirement. But Diane's COBRA insurance will run out in less than two years, at which point she will go on Medicare—and lose her prescription drug coverage.

Diane currently takes 14 prescriptions, valued at almost $1,100 per month. Based on past inflation rates for prescription drugs, Diane's monthly prescription tab could climb to $1,400 per month in the next two years. Without adequate catastrophic coverage, Diane worries that her $33,000 annual income will be cut in half by the time she pays her drug bills, undermining the retirement security she has worked her entire life to achieve. And, in Diane's case, a 50 percent co-pay on top of premiums and deductibles could still result in her paying over a third of her income for prescription drugs—*under either plan.*

Given the principles I outlined, I would counter that the President's Plan represents the better starting point. President Clinton proposes to create a new benefit that is part of Medicare's defined benefit package, and would maintain the voluntary nature of the program—a Medicare Part D. There is no deductible and the monthly premiums are fairly affordable. OWL applauds the President's Plan for making appropriate use of pharmacy benefit managers (PBMs) as a cost containment measure. It is high time we applied the clout of a growing aging population to leverage better prescription drug prices for all seniors.

OWL was also very pleased to see that the President plans to increase the maximum benefit limit from $1000 to $2500 over the 6-year phase-in period. This is a realistic estimate given that the price of prescription drugs continues to increase at 2 and sometimes 3 times the rate of inflation. Starting in 2009, the President proposes to index this benefit to the cost of inflation. We respectfully submit that this element may need to be reevaluated at that time; if pharmaceutical prices continue their typical pattern, raising benefit limits to correspond with the Consumer Price Index will probably not be adequate, perhaps resulting in an erosion of the value of the benefit over time.

OWL would also like to see more specific details for catastrophic and stop-loss coverage in the President's plan, but we are pleased to see the President has recognized the problem and has reserved funds to address the issue. All in all, President Clinton's plan is a healthy start, and OWL applauds him for developing a solid proposal that advances this important debate.

The respective legislative plans aside; I must also say that whenever prescription drug coverage is discussed, there is always an 800-pound gorilla in the room—the issue of price controls. The American consumer is understandably upset that pre-

[15] OWL, *Prescription for Change: Why Women Need a Medicare Drug Benefit,* May 2000.

scription drug costs in the United States are the highest in the world. It seems reasonable that, despite arguments about negatively impacting research and development as well as the potential profit losses for pharmaceutical companies, there is room to explore models that would insure that Americans paid only their fair share for these necessary and beneficial therapies.

Truthfully, we all know that this cat is already out of the bag. As representatives of the American people, I know that Congress is struggling to give their constituents an answer to these simple questions: Why do Americans pay more? And, what can be done to reduce this disproportionate burden on American consumers? Any reform measures you adopt should also address these key public concerns.

OWL looks forward to working with Congress and the Administration to ensure that whatever measures are finally adopted truly work for all older people, including those like Ms. Rudolph. In closing, I respectfully urge all of our policy makers to develop a program that reflects this simple fact: women are the face of Medicare. A Medicare prescription drug benefit may be the single most important improvement Congress can enact for America's retirement health. But if the prescription drug benefit you design doesn't work for women, it just doesn't work.

Mr. MCCRERY. Thank you.

Mr. Donoho?

STATEMENT OF PATRICK B. DONOHO, VICE PRESIDENT, GOVERNMENT AFFAIRS & PUBLIC POLICY, PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION, ARLINGTON, VIRGINIA

Mr. DONOHO. Mr. Chairman, Mr. Rangel, Members of the Committee, my name is Patrick Donoho and I am Vice President of government Affairs and Public Policy for the Pharmaceutical Care Management Association. I am pleased to be here to represent their views before you today on this important issue.

PCMA represents managed care pharmacy and organizations that as a substantial portion of their businessmanage pharmacy benefits. Our members are often referred to as PBMs. We are pleased to provide our association's view on providing coverage for prescription drugs for those individuals enrolled in the Medicare Program.

Our members currently provide drug benefits to more than 10 million Medicare beneficiaries through employer-sponsored, retiree plans or through Medicare-plus Choice plans. Collectively, PCMA members manage prescription drug programs for over 150 million Americans. We are pleased that many of the pending proposals recognize that it would be more efficient to use existing benefit managers in an expanded drug benefit program than to attempt to recreate these capabilities in HCFA.

As the Committee examines various proposals for expanding access to medications for Medicare beneficiaries, we urge you to consider six principles that we believe to be critical to a successful program.

First, the benefit should be delivered in a manner that enhances the health of seniors and the disabled. It is essential that the program not simply pay for the cost of drugs, but also protects the health of seniors. Some drugs are inappropriate for use with the elderly. Others should be used at different dosing levels than are appropriate for younger populations.

Seniors without prescription drug coverage currently do not benefit from the safety of drug interaction screening mandated by

OLGRA 90 for Medicaid recipients and present and virtually all third party programs.

Second, legislation should provide the benefit to the private sector. Competition among private sector PBMs delivers significant cost savings and has spurred innovation in the use of advanced technologies for administering drug benefits. A new drug benefit should embrace and promote competition among these entities and ensure the vitality and innovation through competition.

From prior testimony I have heard the concern about rural Americans. Through drug benefit managers today we contract with most the pharmacies throughout the United States in the mandate given to us by our clients.

Third, legislation should retain flexibility and cost controls within the private sector. Prescription drug coverage for Medicare enrollees must permit pharmacy benefit managers to continue to use such programs as pharmacy network management, formulary development and management, mail service pharmacies, disease management, prescription adherence programs, utilization review and provider profiling for adherence to best medical practices.

Fourth, legislation should encourage continuation of current prescription benefit plans. A new prescription drug benefit for seniors should contain incentives for employers to continue to provide prescription drug coverage to their retirees.

Fifth, a plan should be designed to protect beneficiaries against catastrophic liability.

Sixth, the goal of any agency overseeing the administration of a prescription drug benefit should be to foster innovation and competition. The legislation should not freeze in time the management techniques used today by PBMs.

In examining the several proposals that have been announced or introduced as legislation, we see much commonality in meeting the goals we seek. In particular, most proposals appropriately focus on PBMs, encouraging or mandating the use of the latest tools to improve health outcomes and eliminating medical and medication errors.

Where proposals differ is on whether we as PBMs will have the flexibility we need to control costs. Any legislation that does not empower us as PBMs to negotiate discounts and other pricing concessions from drug manufacturers and pharmacies as we do today in private drug plans will not deliver the anticipated cost savings. Our members are strongly united on this point.

We share the concerns expressed by both the Congressional Budget Office and the General Accounting Office that the political pressures on policymakers and PBMs might limit the tools available to a PBM making it more a transaction processor than a benefit manager. We also share the concerns of some of the authors of proposals that HCFA is unlikely to favor competition over regulation.

Therefore, we are pleased to see that some legislation envisions new structures for administering a Medicare drug benefit.

In conclusion, Mr. Chairman, as an industry we are ready, willing and able to provide our expertise and experience in providing drug benefits to all Medicare beneficiaries.

Thank you for the opportunity.

[The prepared statement follows:]

Statement of Patrick B. Donoho, Vice President, Government Affairs & Public Policy, Pharmaceutical Care Management Association, Arlington, Virginia

Mr. Chairman, Mr. Rangel, members of the Committee, my name is Patrick Donoho and I am Vice President of Government Affairs and Public Policy for the Pharmaceutical Care Management Association (PCMA). I am pleased to appear before you today to testify on behalf of the PCMA.

PCMA represents managed care pharmacy and pharmacy benefit management companies (PBM). Members are organizations that, as a substantial portion of their business, manage pharmacy benefits. PCMA's member firms are an extremely diverse group, including both publicly traded companies and divisions or subsidiaries owned by other healthcare organizations. While many of our members serve broad national populations, some focus on the needs of specific communities such as patients with HIV/AIDS, organ transplants, or cancer.

We are pleased to provide our association's views on providing coverage for prescription medicines for those individuals enrolled in the Medicare program. Our members have a deep interest in the subject of this hearing. Already today, our member companies provide quality, affordable pharmaceutical benefits to more than ten million current Medicare beneficiaries who receive these benefits through their or their spouse's former employers or through Medicare+Choice plans. Collectively, PCMA's members administer prescription drug programs for more than 150 million Americans. All of the major legislative proposals for expanding prescription drug coverage propose using PBMs to deliver these benefits. We are pleased that all of these proposals recognize that it would be more efficient to use existing drug benefit managers in an expanded Medicare drug benefit program than to attempt to recreate those capabilities within HCFA.

As an industry, we have been successful in not only managing the cost of these benefits but also in managing the quality. We know how important good pharmaceutical care is to the elderly and disabled. Therefore, PCMA supports legislative efforts to ensure that all seniors have access to prescription drug coverage. Any program to provide prescription drugs to seniors should rely on the demonstrated drug management experience of the private sector to operate an efficient and cost effective program.

PCMA's Principles

As the Committee examines various proposals for expanding access to medicines for Medicare beneficiaries, we urge you to consider six principles that we have agreed to as an association of member companies to whom much responsibility will be placed by any legislation.

First, the benefit should be delivered in a manner that enhances the health of seniors and the disabled. It is therefore essential that the program not simply help pay for the cost of drugs, but also include pharmacy benefit management services to ensure that seniors obtain, and remain compliant with, clinically appropriate and cost effective drug therapy.

Many drugs are inappropriate for use with the elderly, others should be used at different dosing levels than are appropriate for younger populations. Seniors without prescription drug coverage do not currently benefit from the safety of drug interaction screening mandated by OBRA'90 for Medicaid recipients and present in virtually all third party programs.

Second, legislation should provide the benefit through the private sector. Competition among private sector PBMs deliver significant cost savings and spurred innovation and the use of advanced technologies for administering drug benefits. PBMs develop and administer disease and wellness management programs specifically designed for elderly populations. A new benefit should embrace and promote competition between these entities and ensure the vitality of innovation through competition.

Third, legislation should retain flexibility and cost controls within the private sector. Innovation and creativity in pharmaceutical care has resulted in a number of programs and services that have improved care and managed costs. Prescription drug coverage for Medicare enrollees must permit pharmacy benefits managers to continue this development and use such programs as pharmacy network management, formulary development and management, mail service pharmacy, disease management, prescription adherence programs, utilization review, provider profiling for adherence to best medical practices, and other such programs to manage the benefit.

Fourth, legislation should encourage the continuation of current prescription benefit plans. In order to encourage employers to continue to provide prescription drug coverage to their retirees, a new prescription drug benefit for seniors should contain financial incentives to compensate employers for, and recognize the financial impact of, their efforts.

Fifth, a plan should be designed to protect beneficiaries against catastrophic liability. Recognizing that many seniors have limited incomes and that major or chronic illnesses can impose significant drug costs in a single year, any new Medicare prescription drug benefit should endeavor to include an out-of-pocket expenditure cap.

Sixth, the goal of any agency overseeing the administration of a prescription drug benefit should be to foster innovation and competition for improving pharmaceutical care and the provision of a cost-effective program. PBMs must be able to create financial incentives to encourage Medicare beneficiaries to help control the cost of the benefit. Moreover, the legislation should not freeze in time the management techniques used today by PBMs. To do so would cause the drug benefit to lose the opportunity for innovation and improvement, which has been the hallmark of the pharmacy benefits management industry.

Review of Current Proposals

In examining the several proposals that have been announced or introduced as legislation, we see much commonality in meeting the goals we seek. In particular, most proposals appropriately focus on PBMs, encouraging or mandating use of the latest tools to improve health outcomes and eliminate medical and medication errors. Most proposals also seek to ensure that those Medicare beneficiaries who today have good private sector coverage can keep that coverage by rewarding, through financial incentives, employers that have served well the interests of their retirees by covering prescription drugs within their health benefits. And, importantly, most proposals would address the issue of providing protection against catastrophic costs.

Where proposals differ is on whether we as PBMs will have the flexibility we need to control costs. Any legislation that does not empower us as PBMs to negotiate discounts and other pricing concessions from drug manufacturers and pharmacies—as we do today in private plans—will not be able to deliver the anticipated cost savings. Our members are strongly united on this point. Restrictions on the use of common, private-sector cost containment tools, as we see in some legislation, will deny our members the ability to do what we do best in terms of providing a cost effective benefit in the interests of patients and the taxpayers who will pay for this program.

We share the concerns expressed by both the Congressional Budget Office and the General Accounting Office that political pressures on policy makers and PBMs might limit the tools available to a PBM, making it more a transaction processor than a robust benefit manager. Such tools as managed pharmacy networks and negotiated reimbursements, formulary development and management, and beneficiary cost sharing are examples of areas which may be restricted by a program that is less private sector oriented, and therefore less competitive.

Proposals also differ on the administration of the program. We share the concerns of some of the authors of proposals that HCFA is unlikely to favor competition over regulation. Therefore, we are pleased to see that some legislation envisions new structures for administering a benefit.

In conclusion Mr. Chairman, as an industry we are ready, willing and able to provide our expertise and experience in providing prescription drug benefits to all Medicare beneficiaries. Our support of the various proposals will be based on the authority and flexibility granted PBMs to implement all of their programs to effectively manage costs, foster innovation, and enhance the quality of pharmaceutical care for seniors. We will assess the probability of regulatory limitations, de jure or de facto, on the ability of PBMs to perform this role. We again appreciate your seeking PCMA's views and look forward to your questions.

Mr. MCCRERY. Mr. Schondelmeyer?

STATEMENT OF STEPHEN W. SCHONDELMEYER, HEAD, DEPARTMENT OF PHARMACEUTICAL CARE AND HEALTH SYSTEMS, AND PROFESSOR, PHARMACEUTICAL MANAGEMENT AND ECONOMICS, UNIVERSITY OF MINNESOTA

Mr. SCHONDELMEYER. I am Stephen W. Schondelmeyer. I am a Professor of Pharmaceutical Economics from the University of Minnesota.

I have studied this marketplace, the pharmaceutical marketplace and its structure and economics for about 25 or 30 years. I had the privilege in 1988 to be appointed to the Prescription Drug Payment Review Commission when catastrophic was passed. I was on that 6-month long commission established by Congress and had the privilege of working with folks like Alice Rivlin and others who began attacking these issues.

Also, I have had experience in working with the Health Care Financing Administration evaluating their Medicaid Rebate Program, I have worked with the Pennsylvania PACE Program, Senior Drug Program for the Elderly, probably the oldest and best program in the country.

From that perspective, I bring you my experience and my comments on what I am aware of with respect to the plan that has been proposed at this point, although the details are still somewhat sketchy.

I would comment that we need to be careful with using words like available to all and universal. Technically, all prescription drugs are universally available today if you can afford to pay for them. This document sort of opens that this plan will be available to all if you can afford to pay for the plan and if looks like a good deal for you. So we have to say what does it really mean to say that it is universally available and available to all. I mean that to be serious, what does it mean to call something universal, available to all?

Second, I wish that adverse selection was not a problem but I do have concerns it will be with this particular plan. In my State of Minnesota, we happen to be one of the States where the managed care organizations get such a low payment from HCFA that they cannot afford to offer drug benefits for seniors. The seniors in the State of Minnesota have available to them the three Medigap defined benefit policies that are out there on the marketplace but in Minnesota something less than 10 and maybe less than 5 percent of the seniors ever sign up. The ones who do sign up are the ones who have extremely high drug needs. That sounds like adverse selection to me. So the insurance plans in the area are reluctant to offer those drug plans because it puts a heavy tax on them as well.

With respect to the issue of affordable, I noted in the press release and information about this plan, there is a comment about a savings of 30 to 39 percent over something. It doesn't define what. To my knowledge, the Lewin study that is based on has not been released publicly or is available for others to evaluate.

I would caution to say we must remember that currently no private plan in the country can get a better price than the Medicaid Rebate Plan by law. That is the law you as Congress established and no matter what we talk about in terms of competition in pri-

vate plans, by law, there is no plan that gets a better price than the Medicare Rebate Program today.

I think that is one marker we need to measure against and we need to ask how does that 30 to 39 percent compare with the Medicare Rebate Program and what is that 30 to 39 percent off of. To someone who knows the market, that number doesn't quite balance. We need to examine what is the real and realizable savings from that.

I would comment that you have to deal in a very serious way with inflation adjustment, not just adjusting with the CPI all items of inflation, the one that goes up 2 to 3 percent a year. You have to realize we are talking about a prescription drug plan and prescription drugs have historically gone up faster than inflation, sometimes two or three times.

Just this last year in 1999, prescription drug inflation as measured by the Consumer Price Index was 5.7 percent and it is on its way up. Actually, the December 1999 value compared to December the previous year was up 6.1 percent and the slope is going up right now rather than down.

I think it is partly manufacturers having a sense that maybe something is going to pass with Medicare and we had better raise our prices while we can, much like we saw back with the Medicaid Rebate law. There was a flurry of price increases just before and just after the rebate law but then the market leveled out after that time.

The point I would make there is if prescription drug prices continue to go up at 5 and 6 percent a year and your inflation adjuster goes up at 2 percent a year, that means the value of the benefit over time continually declines. That leads me to the next point.

I am very concerned about the use of an actuarial value as the basis for offering this benefit. I think it would be confusing to the consumer. The task for a consumer with an actuarial value is basically it means the premium will be the same to everyone and then the consumer has to figure out of all these benefit designs and plans that are offered, which one looks like it is going to give me the most.

From the plan's perspective, what a plan would do with an actuarial value is say, what can I do to attract people but deliver the least amount of benefit so I can still make a profit on this. So it is almost a perverse incentive for the plan to take the fixed amount of money, find ways to attract people to the plan but deliver the least amount of benefit so I can make a profit on it.

I think it is much better to have a defined benefit. However, I am not telling you how to define the benefit at this point. I can pick defined benefit A, B, C or D and then my only choice is figuring out. There may be variations in those plans and you can allow some variation within defined benefit plans but then the consumer's choice is how much is the premium for Plan A from this company and this company and which one of those. It is much easier for a consumer to make a choice based on economic value than to try to figure out the structure of the benefit.

I say that with great confidence because just last week I sat down with my mother-in-law whose husband passed away several months ago and she was faced with continuing her health and pre-

scription drug insurance because of the COBRA legislation. She had to make a choice of going to a private insurance outside, continue with the plan my husband had, do I go to a Medigap policy. It was very confusing for her to sort out all of that.

I would tell you I think you need to be very realistic and look at the actual cost structures. We need private health plans, we need PBMs, and they serve valuable roles for us. PBMs have not shown a great record of being able to produce any greater savings than the Medicaid Program. To my knowledge, most managed care benefits, most PBMs have also had 15 to 18-percent increase in prescription drug expenditures in the last several years. I don't see much difference in their performance in the marketplace.

We need PBMs, they are very important. They have the skills that are necessary to run these programs but I am not sure they have done a better job of running them.

I would say if we honestly look at the Medicaid Program versus private plans and ask which is most restrictive, the Medicaid Program is probably the least restrictive compared to most private plans in the marketplace today. Every drug when it first comes on the market is covered by Medicaid. That is not true of most private plans. Private plans have closed formularies, Medicaid cannot do that. Private plans have more extensive prior authorization programs, Medicaid can have prior authorization but under very strict criteria.

So when we ask which type of program really provides the most restrictive or limited benefit, it may be the private plans in today's market more so than a Medicaid type benefit.

I am not telling you which way to go with that but do an honest evaluation of what types of restrictions you are willing to accept.

I would close by saying to be honest and provide fair balance, to get any benefit whether from a government program or a private program, you are going to have to allow that program to implement restrictions because in this marketplace, you negotiate and get better prices on drugs not by volume but by restrictions and by limiting access in one way or another.

Unless you are willing to delegate that authority either to a public or private agency, you won't get better prices by volume.

Mr. MCCRERY. Thank you.

Mr. Kahn?

STATEMENT OF CHARLES N. KAHN III, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. KAHN. I am Chip Kahn, President of Health Insurance Association of America.

As you know, over a decade ago, I worked on the last attempt by this Committee to provide a drug benefit for seniors through the Medicare Catastrophic Act. Later, I staffed Chairman Archer in the repeal of that law. So I have a deep personal understanding of how truly difficult it is to make Federal policy to assist seniors in purchasing drugs.

It is critical, I believe that you make sure seniors understand what they are getting if you legislate on this matter. This and other lessons of the debate are important to draw upon as the Committee examines this complex issue.

I also worked closely with you as well as the other Members of the Committee in the development of Medicare Plus Choice and share your concerns about the future of this program. I believe the future of market oriented approaches to preserving Medicare depends on keeping Medicare Choice viable now.

I believe there is a consensus today that seniors need help with purchasing prescription drugs. Advances in drug therapies have vastly improved medical care as well as the very health of millions of Americans. However, at the same time, these advances have come at a tremendous cost.

A study done for HIAA and the Blue Cross Blue Shield Association by the University of Maryland projects that the Nation's spending for prescription drugs will increase by 15 to 18 percent annually over the next 5 years. This will mean more than a doubling of annual drug costs to $212 billion by 2004. These growing drug costs are particularly a hard squeeze on our Nation's elderly.

We all agree on the goal of helping seniors with drugs but as you and the Committee consider solutions, I urge you to carefully weigh the consequences of the policy alternatives. The lessons of unintended consequences were learned all too well in 1988 and 1989. I will be happy to comment specifically on the drug coverage plan to be marked up by the Committee when the legislative details are made available.

I can say from what I understand of that proposal, it appears to provide a realistic approach to assuring seniors that coverage for drugs will be available to them since it has a fall back. However, HIAA maintains its strong conviction that a private drug only option is unworkable and will not fulfill the expectations of seniors. In my written testimony, I have provided a detailed critique of why our companies believe this and you can read it there.

As you consider options, because of the expensive nature of drug coverage, we are equally concerned that simply mandating that private Medicare Plus Choice plans or Medigap plans cover outpatient prescription drugs will also not serve beneficiaries well.

The proposal recognizes that Medicare Plus Choice plans are severely underpaid and action is needed now to save this important option that so many seniors depend on. Most Medicare HMOs now offer coverage for prescription drugs. However, sustaining this benefit will be difficult since payment inequities and regulatory burdens are major hurdles. Medicare Plus Choice plans cannot continue to offer even the basic Medicare benefits if the status quo remains.

Therefore, for a seniors drug program to be successful, Medicare must make a firm commitment to provide payments to Medicare HMOs that keep pace with escalating medical costs including those for pharmaceuticals.

The proposal for a new Medicare Board to replace HCFA has great potential. Our experience indicates that HCFA has had a difficult time implementing the program and that a fresh start is needed.

Last week, HIAA released a white paper by Bruce Fried, the former director of HCFA's HMO Office. The paper well documents the problems that have caused many HMOs to throw up their

hands and exit all or part of Medicare. I urge you to review the Fried report and consider his recommendations.

I would like to reiterate if Congress and the administration do not address the pressing problems facing Medicare HMOs, it will be difficult if not impossible to succeed at developing true, market-oriented approaches to reforming Medicare.

Thank you. I will be happy to answer any questions.

[The prepared statement follows:]

Statement of Charles N. Kahn III, President, Health Insurance Association of America

Introduction

Chairman Archer, distinguished members of the Committee, I am Charles N. Kahn III, President of the Health Insurance Association of America (HIAA). Before joining HIAA, I devoted a significant portion of my professional life to working on Medicare policy in service to this Committee. I was involved in the first real attempt to provide seniors with access to prescription drug coverage through the Medicare program through enactment of the Medicare Catastrophic Act over one decade ago. I also worked with you, Mr. Chairman, and other members of this Committee on its subsequent repeal. As Staff Director to the Subcommittee on Health, I also played a major role in the development of the Balanced Budget Act of 1997.

HIAA is the nation's most prominent trade association representing the private health care system. Its 294 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. HIAA also is the nation's premier provider of self-study courses on health insurance and managed care. We represent companies offering a broad range of insurance products to our nation's seniors, including Medicare+Choice, long-term care insurance, Medicare Select, and Medicare Supplemental plans.

I am very pleased to be here today to speak with you about how best to increase access to affordable prescription drugs for our nation's seniors.

Seniors Should Have Expanded Access to Needed Pharmaceuticals

Clearly, pharmaceuticals have become a critical component of modern medicine. Prescription drugs play a crucial role in improving the lives and health of many patients, and new research breakthroughs in the coming years are likely to bring even greater improvements. With older Americans becoming an ever-increasing percentage of the overall United States population, the need for more medicines for this sector of the population is becoming equally urgent. There is continuing emphasis on new pharmaceuticals to treat diseases typically associated with aging. Over 600 new medicines to treat or prevent heart disease, stroke, cancer, and other debilitating diseases are currently under development. Medicines that already are available have played a central role in helping to cut death rates for chronic and acute conditions, allowing patients to lead longer, healthier lives. For example, over the past three decades, the death rate from atherosclerosis has declined 74 percent and deaths from ischemic heart disease have declined 62 percent, both due to the advent of beta blockers and ACE inhibitors. During this same period, death rates resulting from emphysema dropped 57 percent due to new treatments involving anti-inflammatories and bronchodilators.

Prescription Drug Expenditures are Rising at a Rapid Rate

These advances have not come without their price. Rapid cost increases are putting prescription drugs out of reach for many of our nation's seniors. Because of both increased utilization and cost, prescription drug spending has outpaced all other major categories of health spending over the past few years. For example, while hospital and physician services expenditures increased between 3 and 5 percent annually from 1995 through 1999, prescription drug expenditures have increased at triple that rate, averaging between 10 and 14 percent. According to projections by the Health Care Financing Administration (HCFA), prescription drug spending will grow at about 11 percent a year until 2008, more than double the rate of spending on hospital and physician services.

A study for HIAA and the Blue Cross and Blue Shield Association by the University of Maryland's School of Pharmacy found that drug spending will increase at an even faster pace than the government is predicting. University of Maryland researchers project that the nation's expenditures for prescription drugs will increase at a rate of 15–18 percent a year over the next five years, more than doubling an-

nual drug spending from $105 billion in 1999 to $212 billion by 2004. According to the lead author of the study, C. Daniel Mullins, Ph.D., 60 percent of those expenditures will be caused by increases in the price and use of drugs already on the market today, while 40 percent will be attributable to the cost of drugs still under development—so-called "pipeline" pharmaceuticals. I have attached a copy of the executive summary and slides from that study, and ask that it be made part of the record of this hearing.

Many Seniors Have Some Drug Coverage, But Benefits Often Are Limited

About two-thirds of seniors have some type of insurance coverage for pharmaceuticals—either through employer-sponsored retiree health plans, private Medicare+Choice plans, Medicaid, or individual Medicare Supplemental (Medigap) policies. But this coverage often provides limited benefits for prescription drugs, and it is likely to decline over time as cost pressures mount for employers, insurers, and individual consumers. For example, recent surveys indicate that employers are contemplating several changes to their retiree health care plans over the next several years, including increasing premiums and cost-sharing (81 percent of respondents to a 1999 Hewitt Associates survey sponsored by the Kaiser Family Foundation) and cutting back on prescription drug coverage (40 percent).

Also, unrealistically low government payments to Medicare+Choice plans are having the effect of reducing drug coverage for many seniors enrolled in these plans. Increases in per capita payments on behalf of beneficiaries enrolled in Medicare+Choice plans from 1997 to 2003 are projected to be less than half of the expected increases during the same period for those individuals in the Medicare fee-for-service program. In fact, the President's Fiscal Year 2000 budget projected five-year medical cost increases of 27 percent for the original Medicare fee-for-service program and 50-percent increases for the Federal Employee Health Benefit Program, while Medicare+Choice payment increases during the same period will be held to less than 10 percent in many counties. The toll these lower payments are taking on drug benefits is already apparent-only three years into the new Medicare+Choice payment scheme. Some beneficiaries now face higher out-of-pocket costs, lower maximum benefits, and higher co-payments on brand name drugs.

Adding to the problems is the fact that most seniors live on fixed incomes and their purchasing power will continue to erode over time as drug expenditures increase more rapidly than their real income. In terms of current dollars, seniors' income has increased very little over the past ten years. From 1989 to 1998, the median income of households with a family head 65 years of age or older increased from $20,719 to $21, 589. This represents an increase in real income of less than 5 percent over the entire decade.

HIAA Has Developed a Solution to Help All Seniors

It is important to recognize that we all share a common goal—to improve drug coverage for seniors. The fact that Members of Congress have chosen different routes to achieving this goal is a testament to the magnitude and complexity of the task.

As this Committee begins to weigh options for expanding pharmaceutical coverage to seniors, we want to bring to your attention several important policy considerations that draw upon our member companies' considerable experience providing health insurance coverage in the private market and through government programs such as Medicare.

In particular, we believe that the potential effects of any new proposal must be carefully examined to ensure that unintended consequences do not erode the private coverage options that beneficiaries rely on today to meet their health care needs. I want to emphasize that, although it has proven difficult to provide affordable prescription drug coverage through the private options available to seniors today (and I will discuss the reasons for that later in my testimony), the private coverage seniors rely on to supplement Medicare is extremely important to them. Medicare covers just one-half of beneficiaries' health care costs and provides no coverage for truly catastrophic illness. Supplemental insurance and Medicare+Choice coverage protect seniors from financial ruin and is highly valued by them for that reason.

Before I outline some of the concerns we have about aspects of several drug coverage plans that have been proposed, let me first make clear that HIAA believes strongly that the status quo is unacceptable. Reforms clearly are needed to expand access to prescription drugs for the nation's seniors. My belief is that the most rational and responsible way to accomplish this is in the context of overall Medicare reform and restructuring. HIAA agrees with many Members of this Committee that broad reforms are necessary and that a sustainable long-term solution to providing

affordable drug coverage for seniors is best accomplished in the context of securing Medicare for the baby boom generation—and beyond.

However, we also recognize that significant steps can be taken in the short term to provide relief to seniors. Last year, HIAA's Board of Directors approved a three-pronged proposal developed by our member companies that would help seniors better afford prescription drugs. The HIAA program would: (1) help lower-income seniors through a federal block grant to expand drug assistance programs; (2) provide a tax credit to help offset out-of-pocket drug costs for all other seniors; and (3) ensure fair payments to private Medicare+Choice plans that are struggling to provide prescription drug coverage for seniors despite unrealistically low government payments that will not keep pace with medical inflation and the projected increases in drug costs.

Nineteen states already have drug coverage programs for low-income seniors; several more are considering such programs in the current legislative session. We believe a federal block grant, with no requirement for state matching funds, would give needy seniors additional support in these states and encourage other states to adopt such programs. Each state would receive a per-capita payment sufficient to cover the equivalent of drug coverage with a $1,500 annual maximum for eligible beneficiaries. States would have considerable flexibility under our approach, and could use the funds to expand existing drug assistance programs or create new ones. We estimate that about 10 million lower-income seniors would be eligible for this subsidy.

The HIAA program also would provide a tax credit to offset out-of-pocket prescription drug expenses for those seniors who file tax returns. A single Medicare beneficiary with income above about 200 percent of poverty (about $16,300) would have been eligible for a tax credit worth up to $1,000 a year, after incurring $500 in out-of-pocket expenses. A couple with an income above approximately 250 percent of poverty (about $28,000) could access a tax credit worth up to $1,500 per year after they jointly paid $500 in out-of-pocket drug expenses. The value of this credit would grow over time to keep pace with inflation. We estimate that nearly 22 million beneficiaries would be eligible for this federal tax credit.

Finally, the HIAA proposal includes a number of measures to assure that seniors choosing to enroll in Medicare+Choice plans are not disadvantaged by unrealistically low government reimbursements. As members of this Committee know, the vast majority of Medicare+Choice plans provide some coverage for prescription drugs and this has proven to be a very popular benefit for seniors. However, inequitable government payments are undermining the Medicare+Choice program and harming seniors who depend on these plans for their health coverage. In effect, the growing disparity between payments to Medicare+Choice plans and per-capita payments for seniors enrolled in traditional Medicare fee-for-service disadvantages the former, forcing them to shoulder an increasing out-of-pocket burden for prescription drugs.

The Balanced Budget Act of 1997 (BBA) reduced payments to Medicare+Choice plans by $22 billion over five years and HCFA plans to reduce payments by another $9.9 billion through "risk adjustment." The Balanced Budget Refinement Act of 1999 restored less than $1 billion of the cuts made through the BBA. Clearly, additional steps are needed: (1) HCFA should be required to implement risk adjustment in a budget neutral manner and the current phase-in should be halted at its current 10 percent level; (2) HCFA should not expand encounter data collection beyond the hospital inpatient setting and should replace the planned universal encounter data-based risk adjustment scheme with a less burdensome approach; and (3) Medicare+Choice payments should be linked more closely to local medical inflation trends.

The HIAA proposal represents an immediate and workable step that will provide meaningful relief for seniors, while avoiding the disruption and confusion for beneficiaries that surely would result were Congress to make changes in seniors' private benefit options before addressing needed changes in the underlying Medicare program. Equally important, it would not foreclose the integration of drug coverage into broader Medicare reform.

Concerns About Private Drug-Only Insurance and Private Sector Mandates

As you work to develop a solution to this very difficult issue, we hope that you will draw upon the HIAA proposal. We recognize, however, that Congress is weighing various Medicare drug coverage initiatives that do not involve block grants or tax credits.

Some of the proposals we have examined that rely on "stand-alone" drug-only insurance policies simply would not work in practice. Designing a theoretical drug cov-

erage model through legislative language does not guarantee that private insurers will develop that product in the market.

Other proposals seek to assure seniors drug coverage by mandating that private health plans—either Medigap or Medicare+Choice, or both—provide enhanced coverage for pharmaceuticals. While this option has the perception of being virtually cost-free from a federal budgetary standpoint, it would be far from inexpensive for seniors who, according to our estimates, would experience premium increases for Medigap products of between 50 and 100 percent. It also would result in many seniors dropping the supplemental coverage they depend upon, possibly creating new public policy challenges. Seniors in rural areas, in particular, rely heavily on Medigap coverage to help them meet their health care needs. If coverage that consumers cannot afford is mandated, the result will be unsustainable premium increases, limited choice, and reduced coverage.

Why a "Drug-Only" Benefit Is Unlikely to Meet the Goal of Universality

Some have proposed that seniors' drug coverage needs could be met through new private insurance coverage options. Theoretically, these "drug-only" policies would be offered either as stand-alone policies, or sold in conjunction with existing Medigap coverage. However, the evidence suggests that it would be extremely difficult to ensure the universal availability of drug coverage to seniors through this type of proposal.

Creating a new form of insurance is not easy. As with any new product, start-up efforts are costly and time-consuming. Adding to the difficulty is that such insurance policies would have to meet existing (and possibly new) dual state and federal requirements before they could be sold. Thus, before making its entry into the marketplace, a "drug-only" policy would have to clear a multitude of economic and regulatory hurdles. Our members have told us these hurdles are likely insurmountable.

Economic Barriers and Adverse Selection Problems

Insurance carriers attempting to bring this type of product to market would face many barriers, including the costs of development, marketing, and administration. Premiums for the policy would have to reflect these costs. Adding to these administrative expenses is the inherent difficulty of developing a sustainable premium structure for a benefit that is so widely used and for which costs are rising so dramatically.

Volatility in pharmaceutical cost trends also will make a stand-alone "drug-only" policy difficult to price. While there has been relative stability in the rate of increase of hospital and physician costs during the past two decades, pharmaceutical costs have been more difficult to predict. In March 1999, for example, HCFA estimated that prescription drug expenditures would reach $171 billion by 2007. Just six months later, in September, HCFA was forced to revise these projections and now predicts that prescription drug spending will reach $223 billion by 2007, *a 30 percent increase over the previous estimate.* Since the Administration first offered its Medicare drug benefit proposal just last year, it has had to revise cost estimates for the program upward by more than 30 percent due largely to greater-than-expected increases in the costs of prescription drugs.

For many reasons, "drug-only" policies would be very expensive to administer. Adding to the economic liabilities of these policies are the expense margin limitations insurance carriers must meet under Omnibus Budget Reconciliation Act of 1990 (OBRA), which are likely to be too small to support separate administration of drug benefits.

The most difficult factor driving up premiums, however, will be "adverse selection." Adverse selection occurs because those who expect to receive the most in benefits from the policy will purchase it immediately, while those who expect to have few claims will hold off purchasing coverage until they believe it is needed. When people with low drug expenses choose not to enroll in coverage while those with high costs do enroll, insurance carriers are forced to charge higher premiums to all policyholders. Higher premiums over time will price many seniors out of the supplemental market. As beneficiaries drop their coverage, premiums invariably will rise yet again—creating what insurers call a rate "death spiral." Moreover, the more opportunities there are for enrollment, the greater the risk of adverse selection.

Adverse selection would be a very real problem for this type of product. Projections indicate that one-third of seniors (even if all had coverage for outpatient prescription drugs) will have drug costs under $250 in the year 2000, with the average cost estimated at $68. These seniors are unlikely to purchase any type of private drug coverage, given that the additional premium for such a policy would be at least 10 times higher than their average annual drug costs. Of the two-thirds who might buy the coverage, many would be doing little more than dollar trading. Some may actually end up much worse off: a person with $500 of drug expenses could have

premium, deductible, and coinsurance costs equal to over 200 percent of the actual costs of drugs. Consequently, many seniors are not likely to purchase the product, resulting in further premium increases for those that do.

Limiting the sale of these policies to the first six months of Medicare eligibility would help in theory only, given legislators' demonstrated proclivity to expand on "guaranteed issue." The Clinton Administration's Medicare drug coverage proposal seeks to avoid adverse selection by limiting enrollment in a government-provided drug coverage plan to the first six months when beneficiaries initially become eligible for Medicare. While this type of rule theoretically helps, the concept seldom works in practice because legislators and regulators expand guaranteed issue opportunities over time in response to political pressure. For example, the "first time" guaranteed issue rule originally in place for Medigap policies has been greatly expanded over time—both through new federal rules in the Balanced Budget Act of 1997 (BBA) and through state law expansions.

Regulatory Hurdles

Even if such insurance policies were economically feasible, they would face significant regulatory barriers. The National Association of Insurance Commissioners (NAIC) would likely have to develop standards for the new policies; state regulators would have to approve the products before they could be sold, as well as scrutinize their initial rates and any proposed rate increases. Even relatively straightforward product changes based on proven design formulas can take several years to progress from the design stage through the regulatory approval process and, finally, to market.

Because insurers would be required to renew coverage for all policyholders (as they are required to do with Medigap products), policies could not be cancelled if new alternatives were authorized by subsequent legislation or regulations. This would exacerbate adverse selection problems for these plans, since people with the greatest drug needs would retain them while others may seek out less costly alternatives. It also would dampen interest in offering the product in the first place, as insurers would be locked into offering these policies once they were issued.

Guaranteed renewability also would exacerbate pricing problems for these "drug-only" products. While many in Congress have said that they oppose government price controls for pharmaceuticals, private insurers offering "drug-only" coverage are sure to face premium price restrictions on their products at the state level (all states have adopted either rate bands, modified community rating, or full community rating for Medigap as well as medical insurance coverage options available to non-seniors). Even when proposed premium increases are consistent with state law parameters, state regulators are likely to be resistant to the magnitude of increase it would likely take to sustain a "drug-only" insurance policy as drug prices grow over time.

If the NAIC did standardize these policies, as some have proposed, it could impose unworkable limitations on insurers. If insurance carriers were prevented from adjusting co-payments and deductibles as drug costs continue to skyrocket, effective cost management would not be possible without significant premium increases over time. On the other hand, allowing needed flexibility would destroy the standardization of Medigap that Congress and the NAIC have worked so hard to achieve during the past decade.

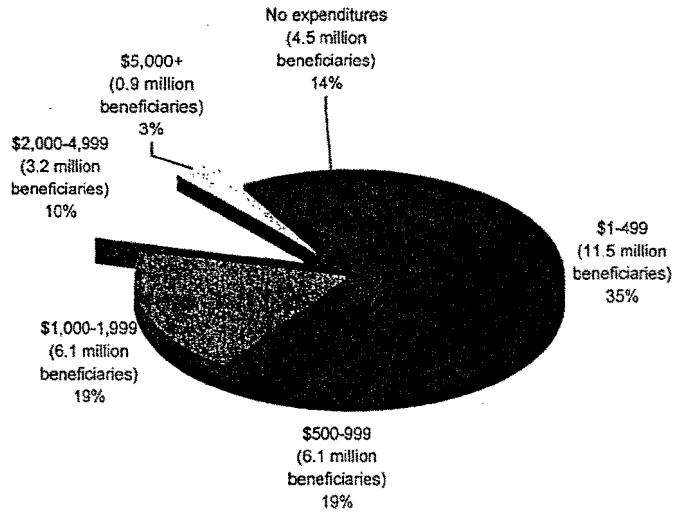
High-Deductible Options Introduce Additional Practical Limitations

Various suggestions have been made to render these policies economically viable. One suggestion that flies in the face of historical reality is to design the policies with very high deductibles—a feature that has never been popular with seniors. Comprehensive high-deductible Medicare+Choice medical savings account plans authorized under the Balanced Budget Act of 1997 (BBA) are not available because no company believes it can develop sufficient market size to make offering such a product worth the effort. It is also notable that the high-deductible Medigap policies with drug coverage authorized under the BBA 97 have not gained market acceptance, largely out of the knowledge that this product would not be attractive to a large enough block of seniors to make it viable. Primary carriers have not entered this market and, as far as we are able to determine, only a handful of these policies, if any, have been sold. The most common reasons for this cited by insurers are: (1) lack of consumer demand; (2) consumer confusion; and (3) unworkable systems change requirements and regulatory barriers (e.g., states will not approve policy forms for 2000 or 2001 because of the federal government's delay in publishing allowable deductible levels). The $1,500 deductible in those BBA Medigap policies is considerably lower than some of the deductible levels proposed by advocates of the new drug-only policies.

Government-Funded "Stop-Loss" Coverage Is Unlikely to Make Such Policies Affordable

Some have discussed providing government-funded "stop-loss" coverage as a way to help those beneficiaries with catastrophic annual drug costs and reduce the cost of private drug-only insurance. While this proposal would no doubt help seniors with extremely large annual drug expenses, it would do little to make drug-only insurance affordable. Nearly nine out of ten Medicare beneficiaries have annual drug costs under $2,000 (see **Figure 1**). Moreover, stop-loss coverage provided to beneficiaries with drug expenses in excess of $2,500 a year would cover just 16 percent of annual drug costs (see **Figure 2**). Stop-loss protection would cover just four percent of annual drug costs if offered to beneficiaries with pharmaceutical expenses above $5,000 per year (see **Figure 3**).

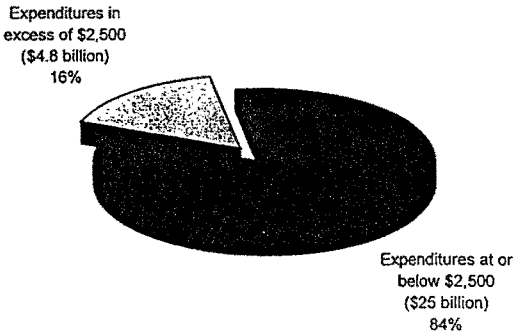
Figure 1
Nearly Nine Out of Ten Medicare Beneficiaries Have Annual Drug Costs Under $2,000[1]



Source: National Academy of Social Insurance, 1999; estimates of 1999 expenditures by Actuarial Research Corporation based on data from the 1995 Current Beneficiary Survey. HIAA estimates for distribution above $2,000.

[1] Expenditures include out-of-pocket spending and third-party payments. Figures are for all non-institutionalized Medicare beneficiaries except those enrolled in Medicare+Choice plan at any point during the calendar year.

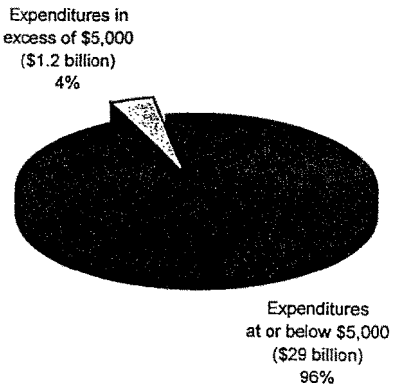
Figure 2
Stop-Loss for Expenses Above $2,500 Will Cover Just 16 Percent of Total Annual Drug Spending by Medicare Beneficiaries[2]



Source: National Academy of Social Insurance, 1999; estimates of 1999 expenditures by Actuarial Research Corporation based on data from the 1995 Current Beneficiary Survey. HIAA estimates of amounts within each category.

[2] Expenditures include out-of-pocket spending and third-party payments. Figures are for all non-institutionalized Medicare beneficiaries except those enrolled in a Medicare+Choice plan at any point during the calendar year.

Figure 3
Stop-Loss for Expenses Above $5,000 Will Cover Just Four Percent of Total Annual Drug Spending by Medicare Beneficiaries[3]



Source: National Academy of Social Insurance, 1999; estimates of 1999 expenditures by Actuarial Research Corporation based on data from the 1995 Current Beneficiary Survey. HIAA estimates of amounts within each category.

In short, a "drug-only" policy is unlikely to meet the promise of guaranteeing all seniors access to expanded prescription drug coverage.

A Drug Mandate Is Also a Bad Idea

Another bad idea is mandating drug coverage for Medicare+Choice plans or Medicare supplemental insurance. (More than 20 million Medicare beneficiaries have Medicare supplemental coverage, with about 9 million policies purchased individually and 11 million through the group market.)

HIAA is strongly opposed to proposals that would require Medicare supplemental insurance or Medicare+Choice plans to cover the costs of outpatient prescription drugs without the addition of prescription drug coverage as a Medicare covered benefit. The growing cost of pharmaceuticals would force plans with mandated drug coverage to raise premiums, increase enrollee cost-sharing, or reduce other benefits, all of which would be counterproductive as seniors dropped their supplemental or Medicare+Choice coverage. Mandated drug coverage could also lead to overly-restrictive government limitations on private plans, such as prohibitions on the use of formularies or mandating certain levels of coinsurance.

Today's Medigap marketplace is convenient and flexible, offering many choices to seniors. Of the 10 standard Medigap policies (A through J) sold, three (H, I, and J) provide varying levels of coverage for outpatient prescription drugs. Largely because of the increased costs of the policies with drug coverage, only a relatively small number of seniors have chosen to enroll in them. Of the 9.5 million Medicare beneficiaries with individually purchased Medigap policies, HIAA estimates that only 1.3 million have drug coverage through the standardized H, I, or J plans.

Several studies show that adding a drug benefit to Medigap plans that currently do not include such coverage would increase premiums dramatically. Seniors who today have chosen to purchase Medigap policies that do not provide a drug benefit

[3] Expenditures include out-of-pocket spending and third-party payments. Figures are for all non-institutionalized Medicare beneficiaries except those enrolled in Medicare+Choice plan at any point during the calendar year.

would end up paying $600 more a year (assuming a $250 deductible for the policy), according to HIAA estimates.

If Congress were to require more comprehensive drug coverage, those premiums could double. According to a May 1999 study by HIAA and the Blue Cross Blue Shield Association, requiring all Medigap plans to include coverage for outpatient prescription drugs would raise Medigap premiums by roughly $1,200 per year, an increase of over 100 percent.

Premium increases of 50 to 100 percent would result in many seniors dropping their Medigap coverage, leaving them without protection against the high out-of-pocket costs of the hospital and physician services not covered by Medicare. Moreover, increases of this magnitude would discourage employers (who are also purchasers of supplemental coverage) from offering such a benefit at all.

It is doubtful, then, that requiring all Medigap policies to include a drug benefit would be popular with seniors—who would experience diminished choice of policies, higher prices, and in some cases, loss of coverage.

Initial Comments on House Republican Drug Plan Concept

Mr. Chairman, while the press has reported over the past several days about aspects of the developing House Republican Medicare drug coverage proposal, HIAA has not had an opportunity to review the details of this proposal. We applaud those members of Congress that have worked hard to address this problem; however, we must reserve final judgment until we have had the opportunity to review the final legislative language. Moreover, from what we do know, the House Republican plan continues to develop.

First, it appears that the proposal will not rely solely on private health plans to meet its goal of offering universal drug coverage to seniors. The "fallback" mechanism that has been reported in the press is a contribution to the debate that we expect to examine more fully in the days ahead.

Second, there appears to be a recognition that Medicare+Choice plans are severely underpaid and that more needs to be done in the short run to save the important private health plan options that many seniors now enjoy.

The vast majority of Medicare+Choice plans now offer coverage for prescription drugs and view this is an important benefit for seniors that they would like to continue offering. However, to the extent Medicare+Choice plans are required to cover prescription drugs, we need to ensure payments are adequate. Under the BBA payment rules, payments to Medicare+Choice plans serving the vast majority of beneficiaries have increased only 2 percent per year, while medical inflation is increasing at 8 percent or more.

Medicare+Choice plans cannot continue to offer even the basic Medicare benefits if this underpayment is not addressed. And as you know, prescription drug costs are increasing at a much greater rate than overall medical spending. Therefore, for this program to be successful, the government must make a firm commitment to provide payments to private plans that will keep pace with escalating medical costs, including those for pharmaceuticals.

Finally, we view the new Medicare board as a potentially positive development. It is clear from our experience that HCFA's implementation and management of the Medicare+Choice program has been difficult. The new Medicare board may allow for a fresh start.

Last week, HIAA released a white paper by Bruce M. Fried, the former director of HCFA's office of health plans and providers, which oversaw the Medicare+Choice program. The paper finds that a combination of inadequate payments and the crushing cost of excessive government regulation are causing HMOs to withdraw from the Medicare program "at an alarming rate."

This is an important point, Mr. Chairman and members of the Committee. In the short term, whether or not Congress is able to pass a Medicare prescription drug benefit this year, immediate steps need to be taken to resuscitate the Medicare+Choice program. Mr. Fried's paper suggests a course of action that includes:

- Congress must increase payments to Medicare HMOs to keep up with medical inflation.
- HCFA should take immediate steps to reduce the administrative burden and expense of prescriptive government regulation, and Congress should exercise its oversight authority to ensure that this occurs.
- Congress should require HCFA to implement risk adjustment in a budget neutral manner and direct HCFA to explore more cost effective—and less administratively burdensome—methods of assessing health risk status. Until a less burdensome system is developed, HCFA should (1) halt plans to collect multiple site encounter data, and (2) freeze the phase-in approach so that no more than 10 percent

of an Medicare+Choice Organization's capitated payment amount would be based on the current risk adjustment method.

• Congress should engage in increased scrutiny of the level and type of administrative burden imposed on Medicare+Choice Organizations and the impact and cost of such burden.

• The Secretary of the Department of Health and Human Services (HHS) should consolidate HCFA's responsibility for overseeing the Medicare+Choice program in one division.

We commend this paper to you, and we urge this Committee to take immediate action to rescue this troubled program. If Congress and the Administration ignore the pressing problems and developments in the Medicare+Choice program, the program will die a slow and painful death, and it will be difficult—if not impossible—to generate industry support for, and involvement in, future market-oriented approaches to delivering Medicare services.

Comments on the Democratic Drug Coverage Proposal

The Democrats' plan to extend drug coverage to Medicare beneficiaries relies primarily on an expansion of the traditional Medicare fee-for-service program. While it avoids some of the problems that would be associated with the creation of private "drug-only" insurance policies, it would create a costly new benefit entitlement without substantive programmatic reforms that are so desperately needed to ensure that the program remains on solid footing for the baby boom generation and beyond.

Moreover, it is far from clear whether payments to Medicare+Choice plans competing with the traditional fee-for-service program to provide prescription drug coverage would be adequate under the Democratic proposal to ensure the long-term survival of the Medicare+Choice program. If these payments indeed prove inadequate, seniors could lose the private health plan options that provide them with high quality coverage today.

Conclusion

The plight of seniors who are struggling to make ends meet and are finding it difficult to pay for medicine is very real. But the immediacy of the problem should not lead to short-term fixes that would do much more harm than good. We believe Congress should step back and examine a broad range of proposals—such as financial support for low-income seniors, tax credits, and fair payments to Medicare+Choice plans, most of which offer drug benefits. We believe there are workable solutions that can meet the needs of our seniors without undermining the coverage they currently rely upon. HIAA stands ready to work with the members of this Committee, and all in Congress and the Administration, to ensure that all seniors to have access to affordable prescription drugs.

Mr. THOMAS. Thank you very much.

I think your last statement may have discovered somebody's motivation for the current structure.

One prescription drug plan used the Consumer Price Index as its inflater multiplier. The other plan used inflation of drug costs as its inflater. From what I understood, the one using the drug costs would be the better plan in terms of staying with the increasing costs versus diminished benefits over time and perhaps being virtually worthless over a decade given difference between the CPI and drug costs. Is that accurate?

Mr. SCHONDELMEYER. That is true in terms of how much benefit would be delivered and how much you increase the funding for that benefit.

Mr. THOMAS. Would you be surprised if I told you the President's plan uses CPI and the bipartisan plan uses the drug index inflater?

Mr. SCHONDELMEYER. I hadn't seen what was in the bipartisan plan.

Mr. THOMAS. At least on that one comparison, it would be better?

Mr. SCHONDELMEYER. Yes. The caveat I would have though is if you do use the CPI for Rx drugs, then it may diminish the incentive for some attempt to hold down price inflation of prescription drugs which I think is a concern also.

Mr. THOMAS. One of the ways you could do that would be to use some of the tools that Mr. Donoho's folk have developed like formularies and tiered pricing and moving toward generic substitution in cooperation with doctors and the rest.

Ms. Briceland-Betts, you indicated you had some fear of the bipartisan plan controlling formularies. How could you also say that one of the criticisms of the plan was that it was basically the private sector being allowed to structure the formularies versus then saying they were going to be somehow limited or restricted? You are either going to be given more freedom to do what you believe is necessary or less freedom but you probably wouldn't be given more freedom to structure and then your fear of not being able to offer a kind of formulary that makes sense.

Ms. BRICELAND-BETTS. I think the point we are trying to make is that there is give and take in every option. While we look at plans that restrict formularies, women have more chronic illness, there is a lot of research as my colleague from PhRMA pointed out on chronic illness which is bringing new and leading edge medications, they tend to be very expensive and she can't buy those out of pocket, she has to have a way within that plan. If the plan has a restrictive formulary to be able to go off the formulary and have access to those.

Mr. THOMAS. If the doctor were to recommend it, there is no plan that wouldn't allow it.

On page four you say "Adequate stop loss protections and catastrophic coverage are critical components in a prescription drug program." I can understand why you wouldn't be familiar with the bipartisan plan since frankly it hasn't yet been in print. What is the President's first year, 2003, catastrophic coverage in his plan?

Ms. BRICELAND-BETTS. I don't think I commented on that in my testimony.

Mr. THOMAS. On page four you said "adequate stop loss protections and catastrophic coverage are critical components."

Ms. BRICELAND-BETTS. They are of any plan.

Mr. THOMAS. What is the President's catastrophic plan in the first year of its implementation, 2003?

Ms. BRICELAND-BETTS. I don't know the answer to that.

Mr. THOMAS. The answer is there isn't a catastrophic plan in the President's proposal in 2003. What is his plan in 2004?

Ms. BRICELAND-BETTS. The point I was trying to make is that because women have lower incomes and higher out of pocket costs and take more prescription drugs, they have to have catastrophic coverage. It doesn't matter whose plan it is, sir.

Mr. THOMAS. I agree with you completely, but if you have one plan that doesn't have catastrophic coverage and the other does, wouldn't you say the plan that has it from day one is a better plan?

Ms. BRICELAND-BETTS. Since I have only seen one of the plans, I was doing my best, sir.

Mr. THOMAS. Which had you seen?

Ms. BRICELAND-BETTS. I have seen the more structure on the President's plan.

Mr. THOMAS. What is the President's catastrophic proposal for the year 2004?

Ms. BRICELAND-BETTS. Maybe not all of the details are in the President's plan but we have seen much more detail.

Mr. THOMAS. The answer is there is no catastrophic proposal in the President's plan. That is the point I am trying to make to you. There is none.

Ms. BRICELAND-BETTS. I know, sir, but the point I was trying to make is how important catastrophic coverage is.

Mr. THOMAS. I know the point you were trying to make. All I am saying is don't put in your testimony that catastrophic coverage is a critical component and not know that the President's plan doesn't have it.

Ms. BRICELAND-BETTS. I was talking about what older women need.

Mr. THOMAS. I agree, older women need catastrophic. That is why the bipartisan plan built in from day one of the proposal a catastrophic coverage, a stop loss for seniors who through no fault of their own have very high drug costs. That is critical to any plan. We put it in from day one. I just thought you might like to know the President's doesn't have it.

Ms. BRICELAND-BETTS. With all due respect, I think what we were trying to do here, and we were very clear, was provide leadership about what older women need as the majority of beneficiaries. Since we haven't had an opportunity to your plan, we were saying one of the things we hope you consider is the importance of catastrophic coverage.

Mr. THOMAS. I agree with you and have you delivered that message to the President since his plan doesn't have catastrophic coverage?

Ms. BRICELAND-BETTS. Yes, sir, we have.

Mr. THOMAS. What was their response? Are they going to do it in 2003?

Ms. BRICELAND-BETTS. They are still examining that, sir.

Mr. THOMAS. Does the gentleman from New York wish to inquire?

Mr. RANGEL. I am just glad you treat the witnesses the same way you treat the Democrats. I yield.

Mr. THOMAS. I can assure you that if a Republican answered the same way, they would get the same treatment. We are here to try to remove partisanship, to try to move a program forward and try to understand what seniors need. I agree, seniors need catastrophic coverage but when one plan doesn't offer it, I think you have to say you are right, it falls short, it doesn't offer it.

Does the gentlelady from Connecticut wish to inquire?

Mrs. JOHNSON. I have several questions. Mr. Schondelmeyer, having been here through catastrophic and seen the reaction, I am interested in your comments about Medicaid. I am not familiar with Medicaid reimbursement rates for pharmaceuticals but I know the real problem for all providers is catastrophically low Medicaid reimbursements for hospitals, doctors and every other provider. They are actually bringing down the system. That comes

from a progressive State that does better than most. Are there reimbursements for drugs sufficient?

Mr. SCHONDELMEYER. The reimbursements to pharmacies are not necessarily sufficient because those are ratcheted down over time and actually pharmacists get about one-fourth less today than they did 20 years ago under Medicaid.

For the drug product component, for single source or innovator drugs, there has never been any price control or limitation on those. It is exactly what the manufacturer sets the price at.

Mrs. JOHNSON. Presumably if we use the Medicaid system to distribute, we would end up distributing drugs at a very low price. I am concerned about the small pharmacist because in many of the rural towns I represent, they are it and there is one of them. We have done so much to put them under already, so this idea of a single pharmaceutical benefit manager that the government would contract with, do you think that will preserve the small pharmacist and do you think their price, if we did it through Medicaid, would be adequate?

Mr. SCHONDELMEYER. Medicaid has been as good a payer as many of the private plans. In fact, some of the private plans have been more aggressive or more damaging to rural pharmacies than Medicaid has.

Mr. FULLER. I would add the CBO report suggests a lot of the reductions as stated have come out of pharmacy. The margin in pharmacy is very, very small. You are right, the small, independent pharmacies for many years have been in decline, although that has leveled off some. A system that puts more pressure on community pharmacy is not only going to detract from the service they should be providing to the patient but is going to financially make it more difficult for them to survive.

Mrs. JOHNSON. One of my concerns is I don't see any plan out there on the table that sufficiently recognizes that people with certain advanced diseases, advanced stages of heart disease or diabetes, not everyone but some portion of those groups will have much lower medical costs if they are in a disease management program that includes not only pharmaceuticals but other components.

What would be the incentive for a pharmaceutical benefit manager to put people in those programs since the pharmaceutical benefit manager isn't going to get the cost savings that accrues to that and yet the public interest is that anyone getting those benefits should be in a disease management protocol.

Mr. DONOHO. I would respond to that by saying if you look at my statement when I said we need the tools, I think when you start looking at defining what kind of tools we have, that is one of our principal concerns.

Mrs. JOHNSON. How would you answer my concern that you wouldn't be motivated to do that because you have to provide the same pharmaceuticals but unless you were a managed care choice plan, you wouldn't get the benefit of lower hospital costs, lower physician visits?

Mr. DONOHO. Because we do those kinds of programs today in the private sector, those are the kinds of programs that we have innovated, developed and we are developing. If you look into the future in terms of where this whole industry is going. Taking silos

away is going to be very important in terms of how prescribing and dispensing practices occur. That is what our industry is evolving into. We are an evolutionary industry.

It is in our best interest to take care of the patient. That is why in my statement I said we have to look beyond focusing on product cost and look at health care.

Mr. KENNEDY. A procedural question. We have less than 10 minutes left on a vote and we have six votes on the House floor. Is it your intention since you are the only majority party member to recess the Committee so we can come back?

Mrs. JOHNSON. I didn't realize I was the only one. Can we get it all in?

Mr. KENNEDY. In less than 10 minutes, I doubt it, not with six votes.

Mrs. JOHNSON. How many of you can come back? Can the members come back too? We will just proceed.

Mr. FULLER. The senior Rx goal proposal we have put forth would require payment for pharmacy services. We think there is plenty of research that indicates that these services improve the patient; health as well as reduce cost to the program.

Mrs. JOHNSON. Do you think most pharmacists can participate in some kind of contract with an insurer or with a reinsurer? I don't want the small pharmacists to be closed out while a big pharmacist takes over through this contracting mechanism. How do we get the small pharmacists into it?

Mr. FULLER. The APHA which represents all pharmacists supports our plan and, I think the kind of proposal we are putting forth they as being workable.

Mrs. JOHNSON. Mr. Stark will inquire and we will recess for the vote.

Mr. STARK. Are your members in California comfortable with the Medi-CAL Program for reimbursement which would be Medicaid in any other State?

Mr. FULLER. I think we have some concerns because much of the burden of reducing costs falls on community pharmacy there.

Mr. STARK. But if we didn't have it, none of those people would be able to buy any pharmaceuticals. In my discussions with the Longs and others, it has been my sense they would be more than happy to continue providing the drugs. They are happy to serve the Medi-CAL or Medicaid community.

Mr. FULLER. It is certainly the desire of community pharmacy to serve that community.

Mr. STARK. I haven't heard that they are complaining as loud as the physicians in terms of their reimbursement, that it is now the law that Medicare beneficiaries must get the same discount as Medicaid beneficiaries in California. I am not so sure that is saving a lot of money for the Medicare beneficiaries, but it seems to be moving all right in California. Do you know anything to the contrary?

Mr. FULLER. I will share with you that the desire to serve the community is great. The ability to continue to do it with the kinds of pressures and low reimbursements they are seeing and the razor thin margins that exist at pharmacy put the future of this in some jeopardy. So proposals that further reduce margins and try to find

more savings at the pharmacy level are ones that we have opposed as an organization.

Mr. STARK. I would agree. I think Mr. Schondelmeyer, what you were suggesting is that the Medicaid regulations probably provide for the best purchase price for pharmaceuticals today, correct?

Mr. SCHONDELMEYER. Right now, they do by law.

Mr. STARK. So by law, we have established the best price anybody in the general public can get for pharmaceuticals. It could be that someone like Kaiser Permanente gets a better deal because they have bigger purchasing power.

Ms. Briceland-Betts, we shouldn't be beating up on you for you not knowing plans that I haven't introduced yet.

Mrs. JOHNSON. If the gentleman will yield, I would just announce that the members will return.

Mr. STARK. In purchasing drugs under Medicaid, is there anything that we could do differently that would get us any better price. Is there anything inherently wrong with setting that rate? We have a government set rate and it gets all the Medicaid beneficiaries the pharmaceuticals they need, correct?

Mr. SCHONDELMEYER. That is true. Medicaid represents about 12 percent of the prescriptions in the country; Medicare, if it covered all elderly drugs, would represent somewhere between 35 and 40 percent of the drugs in the country. There is every reason to think if you have an even larger volume being paid for by the government, you should get an even better price. So you may set a Medicaid type rebate as the floor and then tell the private plans you work with you are welcome to negotiate better prices and if you do, we will exempt it from Medicaid.

Mr. STARK. Wouldn't it stand to reason that fewer larger pharmaceutical benefit managers could get a better discount?

Mr. SCHONDELMEYER. In terms of getting better price, probably yes. In terms of implementing the plan and getting the benefit to meet the needs of populations in certain areas, most of our PBMs are nationwide in scope and can address national structures as well as they could regional.

Mr. STARK. Roughly how many nationwide pharmaceutical benefit manufacturers are there, Mr. Donoho?

Mr. DONOHO. Nationwide PBMs, I would guess over a dozen. We have 36.

Mr. STARK. How many wholesale distributors of pharmaceuticals are there roughly in the country?

Mr. DONOHO. That, I wouldn't know.

Mr. SCHONDELMEYER. At least 100 actual companies and then they have far more.

Mr. STARK. So we have a dozen nationwide benefit plans. They ought to be big enough to get a decent volume discount. If you start to deal with very small ones, they would be at a disadvantage, would they not, in getting a good price?

Mr. DONOHO. I think what you are getting at is the difference between a negotiation over class of trade or market versus setting a price. You as a Congress can set prices.

Mr. STARK. I am. I am just saying wouldn't we be better off with a dozen, as opposed to a couple hundred plans administering these

benefits, because the smaller number of large beneficiary plans would have a better bargaining power? Is that a fair assumption?

Mr. DONOHO. I guess it would be. It depends on the terms. If that is the sole criteria for cost savings. That is one.

Mr. STARK. I guess my time is up.

Thanks for your testimony.

[Recess.]

Mrs. JOHNSON. I apologize to my colleagues. There was a mixup as to who we thought was coming back, so I am sorry to have kept you waiting. I thought you were going on this time.

Mr. McDermott, you are recognized, unless you want to—or you can let Mr. Kleczka go or Mrs. Thurman go.

Mr. KLECZKA. I don't have any questions at the moment, although I might have some after Mrs. Thurman is done.

But the reason that I asked for the Committee to return was so that I could publicly apologize to Ms. Betts for the intemperate remarks of Mr. Thomas.

I think at times some people on this Committee, and maybe in Congress, forget who the boss is, who pays their salary, and to ascertain more knowledge on issues that we're talking about, we ask the public to come here. And if we get to the point where we don't agree with what they say and publicly embarrass and chew them out, I think is wrong.

And so, Ms. Betts, I would like to apologize not only on behalf of this Committee, but on behalf of the entire Congress. That conduct should not be condoned. That is not the way I want this Congress to be viewed, and I don't think it should act as a deterrent for you to say anything you damn well please, whether it be in opposition or in support of my proposal or anyone else's.

So I do apologize on behalf of the Committee.

Mrs. JOHNSON. Before I recognize Mrs. Thurman, I would like to say that I think Mr. Thomas was trying to make a very simple point——

Mr. KLECZKA. But you don't shout at a witness who comes here to try to enlighten this august body.

Mrs. JOHNSON. Mr. Kleczka, I recognized you for your statement and now I'm going to make mine.

I don't condone the tone of voice of Mr. Thomas, but he was trying to make a very simple statement and get a very simple answer. The fact is, the President's proposal never did have a catastrophic component to it. The Republican proposal has always had a catastrophic proposal to it. The later proposal that was generically laid out by Democrats also had a catastrophic proposal to it, and a catastrophic proposal is very, very important.

Now, tempers do get high and voices do get harsh, and I am sorry about that. But frankly, Mr. Kleczka, I have seen—like the colleagues on the other side of the aisle on this very Committee, and I won't name any names—be extraordinarily rude to witnesses when they weren't even trying to make what I considered to be a legitimate point.

So I apologize if anybody's feelings were hurt on the panel, but I certainly would not agree with my colleague, Mr. Kleczka, that somehow Mr. Thomas was way out of order. I have heard far more inappropriate language, tone of voice, and comments from col-

leagues when they also were not at their best, at least as I would claim it.

But let's turn to Mrs. Thurman now.

Mrs. THURMAN. I would yield to Mr. McDermott.

Mr. MCDERMOTT. I have the question that I wanted here.

I don't know who it is on this panel that should talk about it, but as we said over and over again, we don't have the bill in front of us, but the concept that there would be one premium all the way across the country, everybody pay the same thing.

Is it your belief, as a panel, that the insurance companies would charge the same premium everywhere in the United States, that the premium would be the same in Seattle as it would be in New York or New Hampshire? I raise that because in looking at the Medigap policies, you see tremendous variations—the H policy goes from $1,137 in Hawaii to $2,509 in Florida. And what I don't understand is how you're going to have this one premium that's going to cover the whole country.

I would like to hear from those of you who think this idea will work, that it could be done through the private insurance industry.

Mr. KAHN. I think there's a reason that rates vary, and that's because there is some experience that ultimately is used to calculate the rates by actuaries. So I think to the extent possible, insurers and health plans would want the flexibility, based on whatever regional basis was allowed under a law that was ultimately written, to vary their rates. I mean, there's a lot of complaint—I'll give you an example about the AAPCC as a payment mechanism. You know, I will get in line with the people who complain about it. But it does reflect the actual spending on a county-by-county basis on the fee-for-service side of Medicare of what is spent, and there is great variation. Now, some of that variation can be explained, and some of it is mystical. But the fact is that there is such variation, and if you're going to set a premium for an insurance policy, if you don't recognize that variation or if you don't have a pool that is so big that the variation won't affect the ultimate outcome, you're going to have problems with the rates.

Mr. MCDERMOTT. Isn't that an argument, though, for having one plan, so that you get all the benefits of insurance pooling from the whole United States and put them in one bag, and then you can have one? But if you're going to have these regional benefit managers, it seems to me that once you go to regional benefit managers, you're going to have regional programs and you're going to have real problems in having the same premium.

What I struggle with is—I can understand the AAPCC; that is, doctors' pay. Doctors charge $1,000 for an appendectomy in one place and $1,500 in another place. OK, so you've got a variation across the country. But the cost of Kumadin or the cost of antibiotics or anything else ought to be the same, shouldn't it?

Mr. KAHN. You're talking about the price of a particular drug. But the use and the volume and the cost may vary from region to region based on things other than simply the price.

Mr. MCDERMOTT. So the doctors in Florida give more Prozac than the doctors in New Jersey?

Mr. KAHN. It's true with every other procedure; we know that from Wenberg's work.

Mr. SCHONDELMEYER. And it's not just that. It could also be the types of consumers that enroll in the program and seniors that enroll in the program. If in one area, if in Minnesota you get this heavy adverse selection and you just get the people that have more than $3,000 worth of drug expenditures a year, you're going to have real high costs for the program. But if in Florida you get almost everybody to sign up, then the average cost is going to be much lower just because of the mix of people who signed up for the program.

So there are things other than the cost of the drug that will cause variation in the cost of covering the population that is enrolled.

Mr. MCDERMOTT. Cost control—doesn't that argue for having a mandatory program, everybody signs up, everybody's in, so that you get the benefit of pooling and get away from adverse selection?

Mr. SCHONDELMEYER. There are definite benefits to pooling and avoiding the adverse selection.

Mr. MCDERMOTT. But you wouldn't go the next step?

Mr. SCHONDELMEYER. I don't know. It depends on how you do it. I mean, there are ways—and I don't know what's been proposed here—there are ways to do it, either a design way to attract more people in, or a mandatory way. There are variations on how you can get larger populations in, and that's a function of benefit design.

Ms. IGNAGNI. Mr. McDermott, what I understand is that in Mr. Thomas' proposal—and we are looking forward to seeing the details—there would be a specific deductible coinsurance catastrophic set, so that any plan participating would have to meet that basic level. Then, depending upon how efficient the plan was at, for example, disease management, that could be one way that in that sense, by charging the same premium, you could still deliver more benefits. If you were very efficient at disease management and had all the infrastructure in place to do that, you might be able then to reduce the deductible. You might be able to improve on the cost-sharing, or do better on the catastrophic. As I understand it, that is what's being contemplated.

Now, I am not familiar enough with the details of the President's program to know if that would be the case, but in Medicare+Choice, for example, across the board we're allowed to do that. You hit the basic benefits, and then if you're able to improve them because of your ability to coordinate care, and so forth., then you can do that, and that goes to the benefit of the beneficiary.

So it may be common to both.

Mr. MCDERMOTT. So you think it would not work if we mandated that there be a drug benefit of *x* for every plan, every HMO?

Ms. IGNAGNI. Well, I think that what we're talking about—and again, I may be misinformed—but what I understand is that there is a basic requirement. There would be a basic deductible, coinsurance, and catastrophic, and then if you are able to do better than that for the beneficiary, similar to the way we work in Medicare+Choice, then you would be allowed to do that. You would be allowed to reduce the deductible. You would be allowed to try—every incentive would be to make your offering as competitive as

possible, to try to recruit the largest number of beneficiaries, as I understand it.

Mr. MCDERMOTT. Thank you, Madam Chairwoman.

Mrs. JOHNSON. Mrs. Thurman?

Mrs. THURMAN. Thank you, Madam Chairwoman.

Chip, let me ask you a question, because I want to be sure to reiterate this because this is important; I think this is where the differences are. We've all talked about where we have similarities, but we do need to talk about the differences.

In your testimony on page 10 you specifically mention that "Some of the proposals we have examined that rely on 'stand-alone' drug-only insurance policies simply would not work in practice." And you stand by that statement?

Mr. KAHN. Yes. The companies that I represent feel very strongly that this is not a type of insurance that would work if there is risk-bearing involved.

Mrs. THURMAN. OK.

Karen, let me ask you a question as it deals with what you know of the plan that we don't have in front of us. And you've heard this kind of line of conversation with me today.

Today you have Medicare Choice plans based on what they get as reimbursement. Today you have a situation where there are some Medicare Choice programs that in fact provide a prescription drug benefit, as well as other benefits, without any kind of premium. And then you go into——

Ms. IGNAGNI. Very few left now.

Mrs. THURMAN. Right, Okay, Maybe very few now, but even so, even that premium differs from one region to another.

Ms. IGNAGNI. That's right.

Mrs. THURMAN. So what we have then, if you would agree with me, is that we actually have a discrimination issue going on in the entire Medicare Program, because those who have the ability to have Medicare+Choice in their region might have a benefit; it might be a prescription drug benefit; it could be eyeglasses; it could be dental coverage. And then there are other Medicare recipients in this country who have no Medicare+Choice plan that provides them prescription drugs other than in-hospital coverage. Is that correct?

Ms. IGNAGNI. That's right. And the philosophy of this program, Medicare+Choice, as you know, grew out of the Medicare Risk Program. A number of our plans, in fact, have been participating in it for more than 15 years.

The idea was, in exchange for selecting a panel of providers and being in a coordinated care system, along with the ability of our plans to manage the traditional benefit better and more effectively then the exchange with beneficiaries—the "compact," if you will—is that in fact the beneficiaries got more benefits.

Mrs. THURMAN. So the big issue for us right now is the two-tier system. I mean, we basically have done that to the recipients of Medicare who have paid into the system, just like everybody else has in this country.

Ms. IGNAGNI. I don't see it that way, and let me tell you why. We may disagree, but let me tell you why I don't see it that way.

I think that what you have established—and it's long before the Balanced Budget Act of 1997—what you've established is a compact with beneficiaries. There is a basic benefit that the public sector guarantees. Then you say to private sector plans, "If you can improve on that and deliver more benefits for beneficiaries, they will be the ones who will benefit from that," and that's a good thing in the system.

So for the same resources, we can do more.

Mrs. THURMAN. Well, we don't have the same resources going into that.

Let me go to you, Dr. Schondelmeyer. You made a comment—I believe this was your comment—that if we had a prescription drug benefit, that volume purchasing gives us our best price. Is that what you said?

Mr. SCHONDELMEYER. No. Volume isn't what gives price. It's leverage in being willing to switch patients from drug A to drug B, or being able to move patients to a different drug, which essentially tells the drug company, "If you give me a better price, I'll use yours; if you don't, I'll use the other one."

Mrs. THURMAN. Okay. And you have some research that shows what PhRMA and others have been doing in trying to persuade patients in the marketplace, which has really created a problem out there for our programs, is that correct?

Mr. SCHONDELMEYER. Are you referring to research related to direct-to-consumer advertising, things like that?

Mrs. THURMAN. Yes.

Mr. SCHONDELMEYER. I think that is an issue that needs to be examined, because often direct-to-consumer advertising is for products that may not be on the formulary in a specific area, and so a drug company can target the ads to that market and create a whole lot of doctor visits in the HMO where those patients participate. Certainly it may bring some patients into the market who need the drug and didn't know about it.

Mrs. THURMAN. In this conversation can you also talk about what the difference is between the EEU and the United States and those dollars in trying to make that market there?

Mr. SCHONDELMEYER. Well, I'll try.

One aspect of this is, though, that you may get the patient who needs therapy and didn't know about it, but you may also get in the "worried well" or people who, "Oh, I heard about this drug and I called the doctor"—actually, most of the folks I talk to in managed care, while they are concerned about the increased drug expenditure from direct-to-consumer advertising, they are even more concerned about the increased physician visits that these generate. And it is basically that these ads that had another purpose, that create increased costs to the managed care system that they have to cover and work through and pay for and straighten out their patients.

Other countries—the EEU, for example, does not allow direct-to-consumer advertising, and in most of the European countries they regulate either price or profit; and in their regulation process, they determine an amount that they will allow for advertising expenses. The United Kingdom, I think, is in the range of 10 to 12 percent. France is around 15 to 16 percent, although they're trying to

squeeze that down to 10 percent. But in the U.S., the amount spent on advertising, marketing, administrative fees, the same category, is much higher, maybe two or three times as much.

Mrs. THURMAN. And what about research and development?

Mr. SCHONDELMEYER. About the same amount is spent on research and development as a percent of the dollar, but what you have to realize is that the product that costs $1.00 per tablet in the U.S., made by the same company, that product in the U.K. may only cost $0.65 per tablet. So if research and development is 20 percent of the dollar in the U.S., that would be $0.20 spent on R&D. The same tablet bought in the U.K., it would only be 20 percent of $0.65, so it would be about $0.125 or $0.13 spent on R&D from the same product.

Mrs. JOHNSON. I will recognize Mr. Doggett and then I will resume my questions.

Mr. DOGGETT. Well, just continuing along that same line of questioning, in this country, we're paying, or rather, the uninsured are paying the highest prices for pharmaceuticals of anyplace in the world, aren't they?

Mr. SCHONDELMEYER. As best I can tell.

Mr. DOGGETT. And we also have the largest amount of resources devoted to direct advertising of pharmaceuticals of any country in the world?

Mr. SCHONDELMEYER. Yes.

Mr. DOGGETT. As well as a large amount devoted to issue advertising to convince us that paying more for drugs is good for us. And that's one of the things those high drug prices pay for, isn't it? For example, the issue ads put out by Citizens for Better Medicare, FLO, and the like are all paid for with our high drug prices, aren't they?

Mr. SCHONDELMEYER. I presume so, yes.

Mr. DOGGETT. If we were not paying the highest prices in the world for drugs, do you believe that we would have a substantial reduction in research and development?

Mr. SCHONDELMEYER. Well, I don't think that's where a drug company would start. I think they would maybe cut their marketing and advertising budget first. I don't think you start by cutting the R&D because that's the ultimate lifeblood of the company, and you want to keep that producing new products, even when you're squeezed a little bit.

So I think it would probably come more from marketing and advertising, and then maybe in other areas.

Mr. DOGGETT. Why is it that consumers in Great Britain and some of the other EU countries and Canada—your neighbor there in Minnesota—pay significantly less for the very same quality of pharmaceuticals?

Mr. SCHONDELMEYER. Well, you may need to ask that of other people on this panel. I don't know the exact reasons. What I know is that in the U.S., what we call a "free market" really isn't. While it is a "free from regulation market," certainly pharmaceuticals are unique. They are essential. Often, when I go to meet with senior citizen groups, I will ask the question, "Is there anybody in this room who has never used a prescription drug in your life?" And

rarely does anybody raise their hand. Occasionally one or two might.

But the point is, prescription drugs—there is universal demand for prescription drugs, and they affect the very life and health of the person, so they are essential. I would argue that prescription drugs are an essential good, or a public good, much like water or electricity or gas are essential goods to us; and while economics is a great science, and I've spent a lot of time studying it and working with it, what we find out is that the basic principles of economics work when all the assumptions are met. But most of the assumptions in normal economic models are violated in the pharmaceutical market because of the unique nature of the market. It's a life-and-death drug. It's a monopoly situation. It's something you can't live without. If you find out Mrs. Thurman has epilepsy and you have diabetes, and her drug is cheaper, you can't start taking the epilepsy drug for your diabetes just because it's cheaper.

So it's very unique. It's a very different market than any other market in our society.

Mr. DOGGETT. Is there any reason to believe that if we use a Medicare benefit instead of whatever is in the secret Republican plan, that it will necessarily lead to less drug research than if we go with the secret plan?

Mr. SCHONDELMEYER. That's hard to guess because I don't know all the secret plan.

Mr. DOGGETT. I don't either. None of us do.

Mr. SCHONDELMEYER. I don't think any approach—as a matter of fact, I think any meaningful coverage of prescription drugs for the elderly through Medicare will likely result in increased revenue to drug companies. And at this point, realize that when you cover prescription drugs, you have what's called this "insurance effect" or this induced demand that occurs. And most of that is necessary drugs that are used that people couldn't afford previously, so they begin using those drugs. And that will increase the volume of sales to the industry. Remember, they have already made their plans assuming—I don't think they're planning on a drug benefit this year, even though they're talking about it—they have made their plans, so everything that is additional sales because of this is marginal cost sales; that is, it is sales that they make a very high gross margin on. I think Merrill Lynch did a study that suggested that with the increased volume that they have, even if there was substantial pressure on prices, either from the private market or a Medicaid rebate-type program, that they would still be ahead in terms of both revenue and profit and be able to continue increasing R&D as they have, no matter which way you do it.

Mr. DOGGETT. Thank you, and thanks to all of you for staying so long today.

Mrs. JOHNSON. Dr. Schondelmeyer, what percentage of the drugs developed in the United States in the last 3 years are available in Canada?

Mr. SCHONDELMEYER. I have not looked at that specifically. Some things go in the market quicker in Canada; some go in the market in the U.S. I haven't looked at it.

Mrs. JOHNSON. Do you see any discrepancy between the rate at which our designer drugs move into Canada, versus the older types of drug developments?

Mr. SCHONDELMEYER. Canada's system is probably a little bit slower at approving drugs. Probably a better way to say it is that the U.S. system has accelerated in the last two or 3 years and Canada's has kind of stayed where it was.

Mrs. JOHNSON. Well, the reason I asked the question is this. A lot of the drugs that have been developed—and maybe it's not three, maybe it's five—are much more expensive than the drugs that we used to development because they are the development of whole new molecules, whatever. I'm not very good in this area, but I've seen it done. And one of the things that I have read is that those drugs, only about 50 percent of those drugs are going to Canada because the Canadian government will pay quite a lower price because they set their prices at the government level, and no company can afford to take that kind of loss on drugs. So the information I have is that, "Well, drugs are cheaper in Canada, but many of them aren't available."

Now, would you have any comment on that? Or could you provide any research that would give me any indication——

Mr. SCHONDELMEYER. I would be glad to evaluate research that you have seen or been provided.

The comment I would make, though, is that prices are about the same or even less in Europe, and these same drugs end up on the market in the United Kingdom and in Germany——

Mrs. JOHNSON. But, see, that's exactly—what I'm being told is that it is true, that drugs here are cheaper there. But what you're not seeing is the drugs that don't flow over there because a company can't take a loss—in a sense, a loss leader—in all of these. So I think we need to look at the whole market, and particularly in the area of the expensive pattern drugs.

Mr. SCHONDELMEYER. I'm not aware of very many drugs that are on the market in the U.S. that aren't in the United Kingdom or Germany.

Mrs. JOHNSON. OK. I was given some material that showed 50 percent.

Mr. SCHONDELMEYER. I would be glad to examine that, but I haven't seen it.

Mrs. JOHNSON. Mr. Donoho, Mr. Kahn has said that the insurance industry wouldn't want to offer the kind of product that is envisioned in the Republican bill, the bipartisan bill—they are variations of the same thing. But I've had people in my office that are in your business who had reinsurers with them who were excited about offering this product. Would you have any comment on that? Do you believe that pharmaceutical benefit managers, allied with reinsurers, will jump into this market?

Mr. DONOHO. Well, let me be clear about this. We're not in the insurance business today. Most of our members are not insurance agents and don't belong to——

Mrs. JOHNSON. Well, I appreciate that. But they brought a reinsurer along with them to testify to the fact that they were excited about working together on this.

Mr. DONOHO. Right. And I think there are a portion of them—without the correct details before us right now—there is a portion of them that are looking at this as a new way of doing business and they are excited about looking at a new business venture. There is another group of them that are very worried about entering into a new business venture, because it truly is a new business venture for them. But there is a group there looking at new business ventures.

Mrs. JOHNSON. Then I would like to ask any of you who have had a chance to examine the President's plan, which of course has been out there for quite a long time now, he envisions one regional pharmaceutical benefits manager. So instead of insurers, he would set up now, in a sense, a different—in Medicare we have, in every region, someone who manages payments. And when we change people, when there is a competitive issue and we change people, or a service issue, it can be catastrophic to a region, absolutely catastrophic, and I can attest to that. Bills don't get paid. Things go screwy for years.

Now, the President is envisioning only one pharmaceutical benefits manager in each region, and that they would negotiate with this pharmaceutical benefits manager. Now, given the fact that drug prices do vary and patterns of usage do vary, it seems logical to me that people will get different benefits in different parts of the country as a result of the negotiations. Am I wrong to think that? Or right to think that? What do you think, Mr. Kahn?

Mr. KAHN. Well, I think that if we look back in history to the development of part B, we see there that books of regulations were written that set criteria, and then carriers interpreted those, and carriers on part B paid for very different things depending on their interpretation, and there was great latitude given by HCFA to carriers and intermediaries in some cases. So part of the variation in expenditure has come from the varying interpretation of HCFA's rulings, and I think that would happen in this case, too.

Mrs. JOHNSON. I think it's fair to say that the regional variations in Medicare are real. They are not as great as the regional variations in Canada in the National Health Plan which are very great, both in what's covered and in the cost of coverage. Would you agree with that, Mr. Schondelmeyer?

Mr. SCHONDELMEYER. Yes, because in Canada it's provincial plans. It would be like State-run plans.

Mrs. JOHNSON. So there is going to be variation, whether you go with the President's plan or whether you go with our plan, because that's going to be the nature of the beast. So I think it is important to get that on the record.

I do think we look back on a time when so much advertising wasn't a part of the pharmaceutical business, and I think there is some good reason to be thinking of whether or not the government should pay for advertising for prescription drugs since it isn't something that you have a choice about; it's something that your physician makes a determination about, related to your symptoms.

So I am very sympathetic to that approach as one among many possible cost-containing efforts.

But I do thank you for your extraordinary patience today. This is a very difficult area. It is fascinating to me to hear where the

administration's thinking has bogged down, having been a part of the development of this bill and knowing sort of why you don't have the legislative language. I do hope that the legislative language will be out there a long time and that those who really want to work with us, whether they are Members from both sides of the aisle on this Committee or whether they are people in the private sector, will give us their best thoughts. There are so many elements in common from all the plans that it would really be a tragedy if we missed this opportunity. But there are also some terrible problems, and Chip Kahn, almost more than anyone sitting there at the table—except maybe former Chairman Rostenkowski—knows the wrath that went with it.

And I hope, Ms. Briceland-Betts, that you will be prepared to work with your organization, because half of all seniors have less than $200 in pharmaceutical costs. Every one of those people is going to pay more in premiums, and they're going to benefit from this program. Without a catastrophic benefit, they get nothing except more expense. With a catastrophic program, they won't pay $24 a month; they will pay at least $44 a month, or $37 a month, or something like that.

But your organization is going to have to be prepared to be prepared to tell them that this is a good thing, because last time we lost the opportunity to have pharmaceutical benefits because the 50 percent of all seniors who have very few drug costs—and my mother just died at 101; all she had was diuretics and aspirin and stuff like that.

So we have to remember that there are a lot of seniors on very limited income, and we have to be very careful what costs we impose on them, because they aren't going to benefit from this plan. So your organization has to be ready to step up to the plate and say, "This is wonderful, but you're all going to pay more."

Ms. BRICELAND-BETTS. Well, I understand the point you're trying to make, but women spend 22 percent of their income, on average, out-of-pocket.

Mrs. JOHNSON. I appreciate that. But, see, that is on average, and on average, Medicare beneficiaries pay $974 a year. But you're talking about people who have $15,000 drug costs, and then when half pay less than $200, your organization had better have its heels firmly in the ground, its hands firmly on the reins, to get out there and say to people, "We know this is going to cost a lot of you more, but we believe it's going to be good for you," because if you can't say that, then you have to think this through differently.

But that's exactly why we came to the conclusion that without catastrophic benefits, there isn't enough in this for two-thirds. You take the half that are under $200, and then you take those that have better coverage through their employers, and you have to be very careful that you don't rob people of good plans and impose costs they can't afford for a very small slice of people who will benefit.

Mrs. THURMAN. Will the gentlewoman yield?

To Ms. Betts, let me just say this. In talking to the constituents that I have who have had a variety of experiences over the last couple of years, and I can go back to the Medicare Choice stuff, but the fact of the matter is that they've been switched in and they've

been switched out; they've done that. What they're saying to me is, "You know what? We don't mind paying the extra cost because of the cost of drugs and how much they've gone up" and how much they're paying, "but give us a plan. If it's going to cost us $24, if it's going to cost us $36, or $45, give us a plan under Medicare. We understand the program, we know the program, we're comfortable with the program, let us have it." And quite frankly, they want that; with all of the Medicare benefits that potentially they are paying for outside—with Medigap or whatever other plan they've got out there to cover other benefits, including catastrophic. They want an all-inclusive program. I have to tell you, I think that's the problem. If we go out there and shove this stuff at them, with so many different things going on, we're going to confuse them and they're going to be even madder at us than they were in 1986. I wasn't here, but I can tell you, I was in the State Senate and I got the phone calls, saying, "What have you done to our health care system?"

You've got to keep it simple. I mean, we heard these words back in 1992 on an economic plan, "keep it simple, give us a benefit, make it something we can understand. We understand it's going to cost us, but by God, we're tired of paying at a retail price when everybody else is getting it at a preferred customer price."

Mrs. JOHNSON. Of course, as is always the case, simple is mandatory, and there are certain economies when you make it mandatory. But there isn't a lot of support out there, either among Members or seniors, for a mandatory program.

Even with the Administrator's program, it's voluntary. And it could easily get into what you brought up earlier, that only those that had over $3,000 costs in drugs would choose it, and then the costs will be very different than the estimates.

Thank you very much for your patience, as it is extremely difficult. I hope we can come out with something that not only helps seniors, but keeps all the small pharmacies in business. Thank you.

The hearing is adjourned.

[Whereupon, at 6:32 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of James L. Martin, President, 60 Plus Association, Arlington, VA

Mr. Chairman.

On behalf of the 60 Plus Association, I commend you and the Ways and Means Committee for holding this hearing on a topic very important for all seniors, a prescription drug benefit under Medicare.

The 60 Plus Association is a national, nonpartisan senior citizens advocacy group with 500,000 members nationwide, an average of 1,000 per Congressional District. We are supported by the voluntary contributions of our members. We have never in the past nor presently receive federal grants or contracts and we have a policy that we do not seek or would we accept federal grants or contracts.

As senior citizens are living longer and healthier lives, the issue of prescription drugs becomes a major issue for their health and their budget. Years ago seniors lived into their 60s and 70s; now we have seniors living beyond those years, with an increasing population in their 80s, 90s, and even 100 years and beyond. The rational TV weather forecaster, Willard Scott, has a growing number of individuals each year from whom to select to honor on their 100th birthday.

I am not here to endorse any specific piece of legislation but mainly to highlight important principles, which should be included in any prescription drug plan.

First of all, we are very concerned with the proposal pushed by President Bill Clinton. The president's plan is a big government, "one size fits all" proposal that will enlarge government, promises much but delivers little, places decision-making in the hands of federal bureaucrats, and will do little to meet the diverse needs of

our senior citizens. The proposal may have great political appeal in this election year but little common sense appeal to those of us who have studied it. A closer study of the proposal demonstrates that it is a bad program for senior citizens and for the American taxpayer. If we believe we have problems with financing Social Security and Medicare, let us adopt this Clinton proposal and we will have an even bigger financial disaster down the road.

We at the 60 Plus Association are pleased that a bipartisan group is working in the House and the Senate to put forward a proposal, which will really help seniors.

We believe that the essential features of any successful proposal must be a rejection of a big government role and especially one that will lead to price-fixing or price controls by the federal government. Throughout history, price controls have led inexorably to rationing. That's the major reason the Canadian health system is considered by 80 percent of seniors to be in a state of crisis. Rationing leads to long lines in emergency rooms and prompted the Canadian Minister of Health to travel to the United States a few years ago for treatment of his heart ailment.

The United States has one of the greatest pharmaceutical industries in the world. Billions are being spent to develop new drugs, many of which help our seniors live a life with less pain, a higher quality, a longer life, and assist in avoiding surgery. Price controls, especially from an entity with the power of the federal government, could bring such research progress to screeching halt. We would be killing the goose that lays the golden egg. Seniors in order to receive a lower price on a drug today would be risking the opportunity for pharmaceuticals to develop other significant drugs which may help them not only in years ahead but other seniors in future years.

Speaking of the American pharmaceutical industry, it is often used as a whipping boy. For those who participate in this approach, I would like to cite an article that appeared in magazine, September 12, 1998 authored by former House and Senate member Paul Simon. He noted that a heart scan had revealed that he was headed for a heart attack or stroke, even though he had not the usual symptoms of a heart problem such as chest pain or shortness of breath. He underwent a six-way heart bypass operation. He noted that the heart scan developed by research was responsible for him being alive today. He added "Pharmaceutical companies do an excellent job in research" and noted that they had increased their spending from $2 billion in 1980 to $20 billion in 1998. Senator Simon attributed his survival to that research performed by pharmaceuticals.

Seniors are a diverse group. We believe assistance should be provided to those seniors, namely low-income seniors, who need such assistance. We oppose any program that will encourage companies or other health plans to drop their current prescription drug coverage for seniors, a clear and distinct possibility under the Clinton plan. We will be risking some of the great benefits in our current health system for a real shot in the dark by a very risky federal health initiative.

And finally, we should consider the element of choice. We must give seniors this option, and not pass the entire decision-making and funding process on to federal bureaucrats. Seniors must be able to make their voices heard and their decisions known in the marketplace. Seniors will lose this voice if it stifled by a federal bureaucracy under the control of a plan, which has great political appeal (such as the president's) but dire consequences for the financial health of our country and the best interests of our senior citizens.

I urge the Ways and Means Committee to adopt a bipartisan plan, which will really help seniors, and not penalize them with new government entitlement programs of dubious benefits, costly mandates, and excessive regulations.

Thank you.

Statement of American Society of Health-System Pharmacists, Bethesda, MD

The American Society of Health-System Pharmacists (ASHP) supports the work of the House Committee on Ways and Means, to construct a workable Medicare prescription drug benefit. ASHP is the 30,000-member national professional association that represents pharmacists who practice in hospitals, health maintenance organizations, long-term care facilities, home care, and other components of health care systems.

ASHP has followed the debate surrounding the outpatient prescription drug benefit for many years, and applauds the Committee's initiative in working to ensure that this much needed benefit is achieved this year. ASHP believes, however, that a critical facet of the debate has not received the necessary attention to ensure that

the expenditure provides for a high quality and cost-effective outpatient prescription drug benefit to meet the needs of Medicare beneficiaries. As the Committee moves forward in considering this benefit, ASHP asks that you remain cognizant of the critical role pharmacists play in ensuring safe and effective drug therapy management, and include provisions for compensating pharmacists for these vital professional patient care services.

The pharmacists' professional patient care services require pharmacists to work in collaboration with physicians, nurses, and other health care professionals to ensure that medications are used appropriately to improve a patient's health status, improve the patient's quality of life, and contain health care costs. Such activities include, but are not limited to, services that result in the change, correction or elimination of a drug from a patient's drug regimen; initiating drug therapy; training and educating patients on the effective use of their drug therapies; and identifying, resolving, and preventing potential and actual drug-related problems. While other health care providers' services are recognized for compensation, the professional care services of pharmacists currently go unrecognized under Medicare.

This restriction inhibits the pharmacist's unique ability to ensure the proper use of medication therapy. ASHP members understand that providing adequate compensation for these patient care services will save Medicare dollars by ensuring that beneficiaries properly comply with drug regimens, thus preventing adverse reactions and unnecessary readmissions to the hospital. Compensating pharmacists for patient care services ensures that money and resources expended on providing the outpatient drug coverage will yield maximum benefit to the patient and the Medicare program. As the pharmacists' role in the entire drug use process expands, the opportunities for cost control are increased. Significant costs are associated with inappropriate drug choice, adverse drug reactions, and sub-therapeutic treatment. By working with the patients and other health professionals, pharmacists can influence the decision to use a drug. Pharmacists also influence drug selection and patient use throughout therapy duration, assess drug therapeutic effect, and adjust treatment regimen. This integrated approach can reduce the total cost of drug therapy.

Recent studies have also recognized that the professional patient care services of pharmacists reduce costs. A July 1999 article in the *Journal of the American Medical Association* presented the results of a study that concluded that the inclusion of a pharmacist on medical rounds in a hospital's intensive care unit contributes to a decreased number of adverse drug events (ADEs) caused by prescribing errors. Indeed, the study found that the rate of preventable ADEs in an intensive care unit decreased by 66 percent and projected $270,000 per year related to ADEs could be saved when pharmacists were included on patient rounds in large, urban teaching hospitals. In the ambulatory setting, a 1995 study in the *Archives of Internal Medicine* showed that drug-related morbidity and mortality among patients cost the U.S. economy approximately $76 billion annually in direct costs alone. The largest component of this cost was associated with drug related hospitalizations. Pharmacists' patient care services could reduce that cost significantly.

In spite of the clearly positive role pharmacists' professional care services play in improving the quality and cost-effectiveness of drug therapy programs, Medicare law and current legislative initiatives do not allow for pharmacists to be compensated for these services. Efforts to expand on the Medicare program to include an outpatient prescription drug benefit must include a provision for compensating for pharmacists' professional care services. By utilizing the maximum value from the services of our nation's pharmacists, a high quality and cost-effective outpatient prescription drug benefit can be structured to serve the needs of Medicare beneficiaries.

As has become well known since the publication of the Institute of Medicine's report, *To Err is Human: Building a Safer Health System,* medication-related problems are a primary source of medical errors in the United States. These errors result in an inordinate expense, both financially and in the quality of care provided, and result in dissatisfaction with the overall health care system. Seniors are particularly at risk for medication-related problems due to physiological changes associated with aging, as well as their greater consumption of prescription and over-the-counter medications. Adding a new Medicare prescription drug benefit without including a simple, cost-effective safeguard to minimize these medical errors would unnecessarily add to this problem. An effective prescription drug benefit, therefore, would not cover merely the cost of the prescription drug but also measures to enhance the quality and cost-effectiveness of medication therapy. Pharmacists, with their educational background and expertise in drug therapy management, play a critical role in providing essential patient care services that result in a decrease in medication-related problems.

ASHP urges the House Committee on Ways and Means to advance legislation to extend an outpatient prescription drug benefit to Medicare beneficiaries that recognizes the vital patient care services provided by pharmacists.

Statement of Mae O'Dell, as presented by Betty J. Boucher, Reston, VA

I am Betty Boucher speaking for Mae O'Dell #518, Fibromyalgia Osteoarthritis Chronic Pain Syndrome, Multiple Chemical Sensitivity Syndrome

She says Compounded medicine is not covered by Medicaid—If the doctor puts two medicines in the same prescription Medicaid will not pay for it. Alternative health care therapies have to be covered as regular and conventional medicines and methods are not working.

Owes in prescriptions and alternative medicines not covered by Medicaid more than twice her annual income.

She can't afford the monthly payments, she has to borrow, she says Nutritionists need to be covered—they balance our bodies' vitamins, minerals, and give intestinal and digestive help.

These practices do work.

This is only 1/10 of what is wrong as the problems she has cause more problems.

Freda Weltman #524, Takes Calen SR—Blood Pressure, Premeran, Nitroglycerin Baby Aspirin—heart, desperately needs a doctor—any doctor—to prescribe something for her dizziness. This horrible problem has been going on for years. This is not right.

Mrs. Weltman says Kaiser Permanente pays $1,000 a year for all medication and if you need more you have to pay for it.

Another lady has Osteoporosis and Spinal Stinosis—narrowing of the spinal column thus pinching the nerves—sending continuous pain signals to the brain.

Her bones are too fragile for an operation.

She takes $2,000 a year for Oxycontin, Percocet Calcium Supplements Falsomax

The very minimum she pays per year is $3,000—probably much more.

No matter how much money she spends she cannot ever be pain free.

These medications are eating up her resources.

There is a need for research on the continuous pain problem.

Valarie Marizita #513 A tiny, frail lady with terrible asthma, spent five weeks in HCR Manor Care, MCHS Arlington 527, 550 S. Carlin Spring, Arlington, Virginia 22204 (703) 379–7200

Mrs. Marizita stated the young girls from Africa were extremely rude to her. They would slap a towel on her bed and order her to get up and take a bath. They would wake her up in the middle of the night to weigh her. She said she had never been treated so rudely anywhere and has been in many hospitals before. She said she has tried to call their number many times and has never gotten anybody to answer.

Mr. Nevyl Francis, Stroke victim, 11605 Vantage Hill Road, Reston Virginia 20190, was denied ambulance transportation to a hospital and when he did get there was only kept one day! Rationing Health Care! He later died. It was a tragedy!

We need to elect people who will pass the "Right to High-Quality Health Care Act" and fight for a New Bretton Woods financial system. For until we replace the present bankrupt system with a system oriented toward the general welfare (that includes everybody) we are going to be Hitler and have the same "inadequate provision of surgical and medical services" that Hitler provided.

The "inadequate provision of surgical and medical services" that has become a trademark of the HMOs in America, has been absolutely deliberate, as "shareholder value" was placed at a higher priority than human life!

The 1940s to 1960s—Hill-Burton Principle—facilities and care were deliberately built up, with the goal of providing access to care for all citizens. 1946 Hospital Construction Act, 1954 chronic care facilities, 1956 Research against major diseases—Salk's polio vaccine, my own niece had polio, 1963, anti-measles vaccine developed.

How paid for? If the economy was generally growing in the right was, both physical (industry, agriculture, infrastructure) social services (science, education, health care, culture) the tax base, real purchasing power of citizens, philanthropy, community efforts, etc.

During the Nixon Administration (1968–74) a group in 1973 connected with Wall Street and City of London financial circles made sweeping changes—D Senator Patrick Moynihan, R Elliot Richardson, and Henry Kissinger.

In 1971 "wage-price controls," "workfare," welfare 1972 Hospitals receiving Hill Burton funds for 20 years released from obligation to care for the indigent. In 1973 community assets, built for decades bought up for a nickel-on-the-dollar-stripped down, and closed. Privatization in action. HMO Law deregulated hospital care, and opened it up for looting.

All manner of ways to restrict and deny care were approved. The destruction of medical care was deliberate. The rhetoric was to "contain costs," ration "scarce resources" and restrict care. The poor, elderly, and non-white were "not to be cared for" just like Hitler's "useless eaters," and "lives not worthy to be lived."

1999 Medical errors are the leading cause of death and injury in America. Between 444,000 and 98,000 people die in hospitals every year due to preventable medical errors more than breast cancer, highway accidents, or AIDS between 1994–1999.

Almost 1,000 state laws are passed in 48 states to protect patients, doctors, hospitals from managed-care policies. Managed care plans denial, or delay or diagnostic care or treatment result in needless amputations, patient deaths, suicides, invasive cancers and infections.

2000 New York hospitals are offered a "choice" take reimbursement rates that don't cover costs or drop out of the plan.

⅔ of Massachusetts hospitals face 13th quarter in the red. HMOs refuse to pay for billions of dollars of services.

4 out of 5 Pennsylvania hospitals surveyed cannot cover operating costs with patient revenues.

10,000 Michigan hospital jobs have been lost in 18 months. With 7,000 jobs lost in related industries. Non-profit hospitals are forced to reduce/eliminate services and program; some are closed.

AIDS is officially declared by the U.S. government a national security threat. It could easily been stopped.

Statement of Annette Guarisco, Honeywell

Blister Drug Safety Packaging

We appreciate the opportunity to present the views of Honeywell on the important issue of medical errors in the health care system.

As policymakers consider ways to reduce medical and medication errors, such as adverse drug effects, modernize the Medicare system and promote safety for children and adults, the promotion of unit dose/unit of use (known as blister packs) should be considered:

- Blister packs are inherently child resistant
- Blister packs are tamper-resistant and tamper-evident
- Drugs packaged in unit dose formats are protected against cross-contamination
- Efficacy of the drug is maintained for a longer period of time without being compromised when unit dose formats are used
- Special labeling, color coding, is available to designate when and if the drug has been taken when unit dose formats are used
- Blister packaging provides for greater individual product barrier protection against moisture, light and oxygen
- The rate of compliance with unit dose packaging is significantly higher, resulting in fewer and less serious adverse health consequences:
- Contraception—2% compliance rate, vs. 70% for anticoagulants, 82% for organ transplant rejections drugs, 60% for hypertension medication, 80% for asthma, 50–70% for epilepsy, 50–60% for diabetes and 53% for estrogen deficiency drugs
- It was estimated in 1990 that nearly 10% of hospital admissions were the result of pharmaceutical non-compliance and up to 23% of nursing home admissions were primarily due to an inability to manage medications at home.
- When drug regimens are not taken as prescribed, taxpayer dollars are wasted on drugs paid by Medicare, Medicaid, and VA programs, and unnecessary and longer hospital and nursing home stays.
- Unit dose packaging takes less pharmacist time to prepare and reduces the chance for errors, leaving them more time to consult with patients on the proper use of medications.

The recent Institute of Medicine Report, To Err is Human: Building a Safer Health System, called for implementing unit dosing:

If medications are not packaged in single doses by the manufacturer, they should be prepared in unit doses by the central pharmacy. Unit dosing—the preparation of each dose of each medication by the pharmacy—reduces handling as well as the chance of calculation and mixing errors. Unit dosing can reduce errors by eliminating the need for calculation, measurement, preparation, and handling on the nursing unit and by providing a fully labeled package that stays with the medication up to its point of use.

Unit dosing was a major systems change that significantly reduced dosing errors when it was introduced nearly 20 years ago. Unit dosing has been recommended by the American Society of Health-System Pharmacists, JCAHO, NPSF, and the MHA in their "Best Practices Recommendations." As a cost-cutting measure, unfortunately some hospitals have recently returned to bulk dosing, which means that an increase in dosing errors is bound to occur. Page 166–167.

Honeywell urges the Committee to consider ways to encourage drug manufacturers, hospitals, nursing homes, and other inpatient facilities to utilize unit dose formats, and to promote unit dosing in the Medicare and Medicaid systems as well as in the federal employee health benefit system.

We appreciate the Committee's consideration of these recommendations and applaud the Committee for deliberating on the important subject of reducing medical errors.

Annette Guarisco

Statement of National Association of Health Underwriters, Arlington, VA

Mr. Chairman and members of the Committee, my name is Michael Matznick, and I am the President of the National Association of Health Underwriters (NAHU). I am grateful for this opportunity to present our views for your consideration regarding a Medicare prescription drug. NAHU represents more than 16,000 professional health insurance agents and brokers from around the country who service the needs of millions of Americans. NAHU is headquartered in Arlington, VA.

Medicare beneficiaries make up 14 % of the population and are responsible for about one-third of total health care spending.[1] The National Institute on Aging has found that, as a group, older people tend to have more long-term illnesses—such as arthritis, diabetes, high blood pressure and heart disease—than do younger people,[2] and the latest survey data indicate that 86% of Medicare beneficiaries are taking outpatient prescription drugs.[3] The sheer volume of this market should render it a powerful force, yet many Medicare beneficiaries are forced daily to go without needed prescription drugs because their market presence has not provided them with any pricing advantage. The inability to pay for needed drugs, at a minimum, dramatically reduces quality of life, interfering with the ability to have a reasonable lifestyle, the ability to maintain a home, and in some instances means the difference between life and death.

Even though Medicare covers drugs provided while a person is in the hospital, it does not cover outpatient prescription drugs, and one-third of America's seniors either have no insurance coverage at all to assist with the cost,[4] or their insurance plan does not cover outpatient prescription drugs. According to the Senate Special Committee on Aging, this group includes those who are not poor enough to receive Medicaid, do not have employer-based retiree prescription drug coverage, and cannot afford any other private prescription drug insurance plans. Because of this, many seniors must pay the ever-increasing cost of outpatient prescription drugs entirely on their own, and some dangerously limit or eliminate their use of them in order to afford the cost.

Are there solutions to the problem? Some have suggested new government regulation of the pharmaceutical manufacturing industry, although over-regulation of any industry has a serious, harmful impact on access and affordability. The proper path-

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[1] Senate Special Committee on Aging, *Developments in Aging:* 1996, 105th Cong., 1st Sess. 35 (1994) (S.Rpt.403).

[2] National Institute on Aging (NIA), NIA Age Page (1997) (online at www.nih.gov/nia/health/pub/medicine.htm).

[3] AARP Public Policy Institute and the Lewin Group, *Out of Pocket Health Spending by Medicare Beneficiaries Age 65 and Older:* 1997 Projections (Feb. 1997).

[4] Health Care Financing Administration, Office of Strategic Planning, data from the Medicare Current Beneficiary Survey, cited in Margaret Davis, John Poisal, George Chulis, and others, "Prescription Drug Coverage, Utilization, and Spending among Medicare Beneficiaries," *Health Affairs,* Vol. 18, No. 1 (January–February 1999) pp. 231–243, exhibit 1.

way to making outpatient drugs more affordable for America's seniors can better be achieved through the following:

- Coordinated educational initiatives
- Government assistance to low-income individuals
- Fair payments to Medicare+Choice plans
- Free-market initiatives to increase competition and lower prescription drug costs for all Medicare beneficiaries
- Industry self-regulation

IDENTIFYING ROADBLOCKS TO AFFORDABLE ACCESS

Before offering recommendations for solutions, it is important to understand the current situation regarding prescription drug pricing and marketing.

Drug Price Comparisons in Other Countries

It is difficult for America's seniors to understand the huge price disparity for identical prescription drugs in neighboring countries such as Canada and Mexico where price controls and the ability to pay (based on average per capita income) determine retail costs.[5] Most seniors are now aware of this fact, thus explaining the popularity of excursions across the border to take advantage of lower prices. To expand access to the favorable prescription drug pricing available in these and other countries, a number of senior advocates have called for legislation to allow reimportation of prescription drugs shipped under FDA safety guidelines to other countries. A number of logistical and safety questions about this process exist, and it again raises the question—why can't we have affordable prescription drugs for seniors here in the United States? Is there some way we can change the current lopsided arrangement where U.S. citizens bear the burden for the entire cost of research and development, while other countries pay only the cost of manufacturing, a small amount of profit, and little else? Do we really have to reimport our own products just to get a fair price at home?

Drug Price Comparisons in Humans vs. Animals

In addition, recent studies indicate that there is disparity, even within the United States, for **identical drugs** prescribed for humans vs. animals. In a recent study done on eight brand name drugs, same dosages by the same (or related) companies were on average 106–151% more when the drug was intended for human use than when the drug was intended for animal use. In dollar terms, the price differential is substantial. A popular arthritis medicine used in the same dosages by both humans and dogs, Lodine, is $108.90 for a one-month supply when the drug is to be used by humans, but only $37.80 when the drug is to be used by dogs. Another drug with a large price difference is Vasotec, a high blood pressure medication that was the 14th most frequently prescribed human drug in the United States in 1998. Merck charges $78.55 for a one-month supply when the drug is to be used by humans, but only $51.30 when the drug is to be used by dogs. These and other identical drugs are on average twice as expensive when prescribed for humans than they are when prescribed for animals, a differential that cannot be adequately explained by quality differences or research costs.[6]

Drug Price Comparisons between Uninsured Consumers and Large Purchasers

The Congressional Budget Office (CBO) has also confirmed that different buyers in the United States pay different prices for brand-name prescription drugs, and purchasers who have no insurance pay the highest prices.[7] According to the Federal Trade Commission, a notable example of differential pricing is the "two-tiered pricing structure" under which pharmaceutical companies set lower prices to large buyers like hospitals, HMOs and pharmacy benefit managers, and charge higher prices to other buyers that include the uninsured and independent and chain retail pharmacies.[8] Because preferred buyers buy in bulk, some difference between retail prices and "favored customer" prices would be expected. However, the differential for prescription drugs is much higher than for other consumer items purchased in bulk.

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[5] Congressional Research Service, *Prescription Drug Price Comparisons:* The United States, Canada, and Mexico (January 1998)

[6] Minority Staff, Special Investigations Division, Committee on Government Reform, U.S. House of Representatives, *Prescription Drug Price Discrimination in the 7th Congressional District in Maryland: Drug Manufacturer Prices are Higher for Humans than for Animals,* February 16, 2000.

[7] Congressional Budget Office, *How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry,* xi (July 1998).

[8] Federal Trade Commission, *The Pharmaceutical Industry: A Discussion of Competitive and Antitrust Issues in an Environment of Change,* 75 (Mar. 1999).

A recent study showed that the average price differential for five commonly prescribed prescription drugs was 133%, while the price differential for other consumer items was only 22%.[9] Compared to manufacturers of other retail items, it appears that manufacturers are taking full advantage of the "life and death" necessity of the items they manufacture and market, and are charging "what the market will bear" in each of the markets in which they operate. Therefore, in Canada and Mexico, they charge less because (a) some price controls exist and (b) the per capita income of citizens is such that they would be unable to pay higher prices. In the case of animals, what an individual can and will pay for treatment of a pet or other domestic animal may be far less than if the treatment were required for themselves or a family member. In the case of large purchasers, the high amount of competition among manufacturers for their drug to be included on the "preferred list" of large purchasers results in manufacturers offering large discounts to large purchasers in order to win their business.

Direct-to-Consumer Advertising

As with other commodities, the law of supply and demand has a dramatic impact on price. When demand is influenced by outside factors, such as advertising directed to consumers for prescription drugs, patients demand that their physicians prescribe these medications. These consumers have additionally been led to believe that only the "name brand" medication will successfully treat their condition, thereby making generic drugs seem inferior and less effective. Physicians are reluctant not to prescribe the medication requested by their patient if they determine that it will do the patient no harm and may, in fact, help them. If demand is high enough, the volume of sales **should** result in greater profits for manufacturers and the ability to lower prices, although this rarely happens today. If demand is too high, the supply of some medications may be inadequate to meet demand, and, as in other markets, the cost of the prescription drug will increase. **Direct-to-consumer advertising also increases overall prescription drug utilization.** Many medications prescribed as a result of direct-to-consumer advertising are new prescriptions for the patient, as opposed to a replacement of an existing prescription, and are added to the medications a consumer may already be taking.[10] This increase in overall utilization increases total out-of-pocket spending on prescription drugs for these seniors, many of whom live on fixed incomes. This is part of the reason that spending on outpatient prescription drugs has increased 11% per year for the past five years.[11] Some would argue that these new prescriptions will replace more costly surgeries, but although the medication may delay the need for surgery, the surgery may ultimately be needed anyway as the prescription drug loses its efficacy over time. Although we would not argue that quality of life is improved in the interim, the fact is that, ultimately, insurers and consumers may have borne the cost of both the surgery and the medication.

A further concern with direct-to-consumer advertising is lack of consumers' understanding of direct-to-consumer advertising regulation. Recent surveys indicate that fewhealth professionals and even fewer members of the general public understand the regulations surrounding drug promotions. Half of the respondents of the survey believed that ads had to be submitted to the government for prior approval, and 43% believed that only "completely safe" drugs could be advertised, even though advertising for prescription drugs is not subject to this type of federal oversight. Thus, a large number of consumers believe that prescription drug advertising directed to consumers carries the endorsement of the federal government.[12]

RECOMMENDATIONS

Coordinated Educational Initiatives

The first step in this process needs to begin with the physician. A physician education process should be initiated by physicians' organizations, such as the American Medical Association and other physician specialty organizations, on drug efficacy, interaction and the differences and similarities between name-brand and generic drugs. Although physicians depend on drug manufacturers to help them stay abreast of the latest treatments, their dependence on drug manufacturers may also

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[9] Minority Staff Report, Committee on Government Reform, U.S. House of Representatives, *Prescription Drug Pricing in the 7th Congressional District in Maryland: Drug Companies Profit at the Expense of Older Americans,* April 21, 1999

[10] Direct to Consumer Prescription Drug Advertising: Trends, Impact, and Implications, *Health Affairs,* March/April 2000, Volume 19, Number 2

[11] Health Care Finance Administration, *National Health Expenditures* (1999) (online at www.hcfa.gov/stats/nhe-oact/tables/t10.htm).

[12] *Health Affairs,* supra, note 10.

mean that physicians will have somewhat limited and biased information about prescription drugs. An educational campaign from their own professional association would be well-received by physicians and would provide the balance and continuing education they need to do what is best for their patients.

Additionally, studies have shown that many physicians do not like direct-to-consumer advertising because it encourages demand for treatments that may not be medically indicated and boosts inappropriate requests for specific medications. The medical community would be well served to develop a systematic, ongoing medical literacy campaign of its own to inform consumers of the promotional nature of direct-to-consumer advertising, as well as the regulatory context in which it is designed. For example, clinic waiting areas, hospitals and other healthcare locations could be used to disseminate reminders to consumers that advertisements in the media are promotional and do not necessarily represent the most objective advice.[13]

A recent survey by Merck-Medco found that 76% of those surveyed would choose generic medications if their doctor assured them that the generic drug is a safe and effective alternative to the brand-name drug.[14] Consumers should be educated about FDA requirements as to pharmaceutical and therapeutic equivalence and that buying and using a generic drug is much different than buying a generic can of peaches. In fact, according to Jane E. Henney, MD, commissioner of the Food and Drug Administration in JAMA, December 1, 1999:

"Questions have been raised recently about the ethics, safety and effectiveness of generic substitutes for brand-name products... practitioners and the public may be assured that if the FDA declares a generic drug to be therapeutically equivalent to an innovator drug, the two products will provide the same intended clinical effect."

To assist physicians with patient education, a special consumer-education campaign needs to be undertaken. The campaign should emphasize the cost components in prescription drugs, how formularies, mail order and drug discount plans work, and how consumers can bring down the cost of medications through the use of these programs and appropriate product selections, including selection of generic medications. Included in this campaign would be a special educational piece that physicians can give patients who request a specific name-brand medication This piece, as well as other educational materials, would be available in different formats, including print, Internet, video and public service announcements in all mediums. Educational materials would be developed as a joint effort of provider organizations, consumer groups, insurance carriers, brand-name and generic drug manufacturers, health insurance agents and the government, and would be designed to place in the unique context of patient care why a prescription drug advertised on TV or in print may or may not be appropriate. Consumers would be provided with accurate information discussing the proper use of prescription drugs, and safe ways to lower their costs, including the proper use of generic medications, or when a name-brand drug might be the best treatment choice. This would not mean a recommendation that consumers always purchase generic drugs, but that they have balanced information to help them make wise purchasing decisions.

Another way to provide consumer education would be through pharmacists. Merck-Medco's study indicated that consumers rely heavily on the advice of their pharmacist, and that two out of three adults indicate that they have purchased generics on the advice of their pharmacist. Current law requires pharmacists to offer consumers a choice between a name-brand drug and a generic medication when the physician has not restricted the prescription to the name-brand drug. NAHU would like to see this expanded to require that the pharmacist also verbally advise the patient of the cost difference between the two choices. If the pharmacist's question is "Would you like the name brand or a generic?" the implications of that choice are not as clear as if the question were "Would you like the name brand for $200 or the generic for $68?" This cost comparison is critical, and the majority of adults categorize this as a major reason for choosing a generic drug, **if they are aware of the cost differential.**

Finally, the consumer-education campaign should also stress the importance of lifestyle changes such as a low-fat diet, exercise, stress management and allergen avoidance, rather than a reliance on a "pill for every ill," contributing to medicalization of trivial ailments and an even more "overmedicated" society.

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[13] *Health Affairs,* supra note 10.

[14] Merck-Medco, L.L.C. Survey of adults 18 years or older in order to determine their knowledge and opinions of and experience with generic prescription drugs. Survey performed by Bruskin & Goldring Research, March 1999.

Government Assistance to Low-Income Individuals

NAHU recognizes that more efficient buying habits alone will not provide needed medications to everyone, and we strongly encourage Congress to address overall Medicare reform as quickly as possible to remove current inefficiencies and outmoded programs and practices to bring Medicare into the 21st century. Even before this is accomplished, however, we strongly recommend that the problem of outpatient prescription drug coverage for low-income Medicare beneficiaries who are not already eligible for Medicaid be addressed incorporating and using the cost-effective purchasing strategies and patient incentives described elsewhere in this paper. This could be accomplished in the following ways:

- Expand information on the subsidies already available at the state and federal level for low-income beneficiaries (QMB, SLMB, state programs).
- Provide additional federal subsidies through block grants to states to expand existing programs (non-Medicaid) for low-income beneficiaries or to begin new state programs for low-income Medicare beneficiaries. **These federal subsidies would not require a state match as is required through the Medicaid and Children's Health programs** and would allow flexibility to states to use the resources available in their own areas. If used in conjunction with pharmacy benefit managers using formularies, rebates, therapeutic substitution and incentive pricing to encourage the use of the most cost-effective medications, coverage for prescription drugs could be extended to many low-income beneficiaries who have no assistance with these costs today.

Fair Payments to Medicare+Choice Plans

One of the best ways to ensure that seniors have access to affordable prescription drugs is to increase Medicare+Choice plan reimbursement rates, so that all Medicare+Choice plans can provide pharmacy benefits, not just those in the higher reimbursement regions. There is a large disparity among regions of the country in the government's payments for seniors enrolled in Medicare+Choice plans. As a result, some concerns have been raised about the financial viability of Medicare+Choice plans. Many Medicare+Choice plans already provide some coverage for prescription drugs, and they have been able to use many of the cost-effective strategies described elsewhere in this paper. A growing trend in payment disparities, however, will cause seniors enrolled in private Medicare+Choice plans to be clearly disadvantaged due to underpayment to plans forcing them to reduce or eliminate their prescription drug coverage and, in some instances, withdraw from areas altogether. Prescription drug coverage is one of the most popular benefits offered by Medicare+Choice plans today. Adequate compensation and flexibility in plan design to meet market demand will enhance the accessibility of drug benefits for seniors.

Free-Market Initiatives to Increase Competition and Lower Prescription Drug Costs for All Medicare Beneficiaries

Price negotiation for prescription drugs already occurs regularly in the marketplace through managed care arrangements such as HMO plans, PPO plans and pharmacy benefit managers, to name a few. Some people point to these negotiations as an indicator that price controls can work in the belief that if private industry can negotiate prices, the government can, too. On the contrary, these negotiations in the private sector are negotiations among equals. Price controls that attempt to replicate such discounts for everyone would undermine the incentive for negotiating the discounts in the first place. Price controls would actually undermine existing pricing competition by substituting federally mandated discounts for the play of market forces.

While many other countries have passed laws limiting the cost of drugs, the United States has not. Since prescription drugs are significantly more expensive in the United States than in other countries, some have suggested that Congress should legislate price controls similar to those used in other nations to eliminate cost shifting to the United States. While this "quick fix" sounds tempting, this approach could seriously undermine the system that has worked in most other American markets—**competition.**

The idea that price controls really "control price" is based on the theory that government can allocate resources better than consumers and providers in the marketplace. If prices are not free to go up and down according to market conditions, seniors could face shortages of some current and future medications due to insufficient research and development resources. In addition, price controls in health care are blatantly inconsistent with government strategies to spur competition in other industries, where the government has attempted to break down monopolies, deregu-

late price and foster healthy competition in a variety of ways by assuring a fair playing field.

It is undisputed that the current development process of new drugs is an expensive, lengthy process. Only one in 10 new drugs successfully makes it to the market. The price consumers pay for successful products helps pay the cost of the many failures. Price controls could discourage the development of drugs and biotechnology products for older Americans. The development of new products for seniors, for example those afflicted with Alzheimer's, would be severely impacted by price controls and manufacturers would very likely respond by allocating funds for research and development to products designed to be used by other populations, to assure a more profitable return on their investments. Why should they focus on drugs for the elderly if they cannot recoup the cost of research?

Managed Prescription Drug Care

Managing the cost of prescription drugs in health plans works the same way as managing care for doctors and hospitals. Consumers must give up some of the choice they would otherwise have, but in exchange, they are assured of getting the pharmaceutical care they need. To manage the cost of prescription drugs, most HMOs and many other managed care plans establish a formulary—a preferred list of drugs eligible for coverage under their plan for reasons of efficacy and cost. These drugs have the same therapeutic effect of other non-formulary drugs, but by giving them preferential purchasing status, volume discounts can be negotiated.

Virtually all health plans today that offer outpatient prescription drugs to their insureds through a "prescription drug card" use pharmacy benefit managers to help them negotiate discounts, even when they don't use a formulary. These pharmacy benefit managers are extremely successful in negotiating volume discounts, which decreases the cost of medications to the health plan.

The group buying power that Medicare beneficiaries could have goes largely unused because it is too unorganized today to leverage its potential strength. Medicare beneficiaries often pay retail prices in spite of their large numbers, even though drug discounts for HMOs and hospitals can be as high as 40 percent. Those who get discounts based on their age for other services, such as when they go to the movies or ride public transportation, are naturally upset at the disparity when it comes to buying prescription drugs. So, how can we implement a similar strategy for Medicare beneficiaries capitalizing on their private-market purchasing clout? Rather than imposing new government mandates that would require a certain level of discount for seniors, NAHU again suggests that we look to the successes of the private sector for a solution. Employers, business coalitions, unions and state and federal agencies all take advantage of group purchasing and many of these entities purchase through pharmacy benefit managers. These arrangements have produced savings, better quality, more education and enhanced benefits for their members, not through mandates, but through market forces in the private sectors.

Some health plans, such as some Blue Cross organizations, have begun to extend the discounts they have negotiated through the pharmacy benefit managers, with whom they contract for their under–65 insureds, to their Medicare Supplement policyholders. **This allows policyholders to purchase their outpatient prescription drugs at significantly discounted rates, even though outpatient drugs are not specifically covered by their Medicare supplement plan.**

Utilizing competing pharmacy benefit managers to negotiate discounts for Medicare beneficiaries would give them a choice among several pharmacy benefit managers in their area, making them eligible for a "prescription drug card" that would guarantee them the discount negotiated on their behalf. This could be done with little or no cost to the federal government and the free-market competition among **competing** PBMs would ensure the best possible discounts for seniors. This discount system would be available to all seniors, regardless of income, and could also be used in conjunction with state programs for low-income seniors. These entities would make full use of formularies and other incentive pricing programs to encourage seniors to use the most cost-effective medications. Rebates would be used to reduce the cost of drugs to seniors, ensuring seniors the best possible price. Since this would not be an "insured" program, there would be no assignment of "risk," and adverse selection would not be an issue. Seniors could select freely from the PBM offering them the best combination of convenience, cost and education on pharmaceutical issues and disease management. To ensure maximum patient safety and offer the maximum level of protection against medication errors, competing PBMs would have the ability to transfer patient records if a beneficiary moved or otherwise changed his choice of PBM.

We also recommend that Congress move towards greater price equity in the cost consumers pay in the United States for prescription drugs vs. the prices paid in

other countries. This can be done by simplifying the ability of consumers, health care coverage companies and others to buy legally prescribed drugs from other countries when they are identical to the same medication available in this country, and when they are manufactured, stored, and shipped according to Federal Drug Administration guidelines. Additionally, to promote greater equity among nations, and to provide the most affordable access to consumers, the Federal Drug Administration should consider converting to over-the-counter status any drug that the manufacturer is selling on an over-the-counter basis in at least five developed countries.

Finally, we recommend that Congress consider the use of non-refundable tax credits for persons without prescription drug coverage through either Medicare+Choice or a Medicare supplement plan for middle income beneficiaries between 200% and 400% of poverty. This would provide assistance to individuals who pay taxes and file tax returns but still have difficulty in making their income stretch to cover outpatient prescription drugs in addition to housing, food and other necessities.

As we have illustrated throughout this paper, price controls are not the answer to the current high cost of prescription drug coverage for America's seniors. The pharmaceutical industry must do its part in making prescription drugs more affordable for all consumers, including Medicare beneficiaries. For many years, physicians, hospitals and other healthcare providers have negotiated the prices they charge for their services based on volume purchasing by government, employer, union and other health plans. Drug manufacturers and pharmacy benefit managers have participated in these negotiated discounts resulting in reduced prescription drug costs for those covered by the plans. While this participation has been helpful, it has not benefited those not covered by these plans, many of whom are Medicare beneficiaries, and it has not produced low enough costs even for those covered by managed care plans, regardless of the population covered by the plan. With profit margins averaging 28.7 %, compared to 10.5 % for other successful industries, and consumer outcry at an unprecedented level, the pharmaceutical industry should wisely elect to self-regulate to avoid new government mandates. This self-regulation needs to include:

- implementation of clear cost reduction for name-brand medications at the end of the patent period;
- development of consumer education that focuses on proper usage of both name-brand and generic drugs without focusing on one particular drug;
- initiation of voluntary reduction of prescription drug prices to state prescription drug programs for low-income individuals;
- re-allocation of dollars currently designated to physician entertainment to providing new technologies to physicians to assist them in prescribing accurately. An example of this, in states where it is allowed, would be a computer program or device based on the *Physicians Desk Reference* that would actually result in a legible printed prescription for the patient. This interactive program requires input of a diagnosis and would prevent prescribing errors as a result of confusion over similar drug names, dosage errors and the inability of a pharmacist to read the physician's handwriting. In states where actual electronic prescribing is prohibited, the educational components of this system could still be provided to the physician. An essential element of this system would be its universal nature, with information provided on products produced by all manufacturers, and clear disclosure of the names of generic equivalents and their availability;
- assurance that product package inserts are written at a level and type size appropriate for most readers;
- attention in product promotions as much to side effects as to treatment effects;
- less or no emphasis on technical graphs and charts or pseudoscientific jargon in product promotions, ensuring less confusion to the consumer;
- advertisements to consumers that are less centered on the medication and more on the disease or condition to be treated;
- advertising and promotional marketing to practicing physicians and medical students that is balanced and should include information on prevention of pharmaceutical errors.

CONCLUSION

The problem of access to affordable prescription drugs for America's seniors is a serious and growing concern. It is critical that all Americans should have affordable access to the rapid advances being made in medicine, including pharmaceutical products. The best way for seniors to truly have this type of control over their health is:

- education on issues related to obtaining all types of health care, including the options available for prescription drugs;

• government purchasing assistance for the needy;
• market force buying power to obtain better outpatient prescription drug prices for all seniors to allow them to take advantage of their numbers for the drugs they need to maintain a strong and healthy lifestyle;
• responsible self-regulation by pharmaceutical manufacturers.

A united and dynamic force that includes private industry, medical professionals and government can bring the gift of empowerment to our senior population rather than new and costly dependence on government programs.

Thank you for considering our views. NAHU and its members look forward to working with Congress in addressing the pharmaceutical needs of America's rapidly expanding segment of Medicare beneficiaries.

Statement of Tom A. Wilkins, Reston, VA

Good morning Mr. Chair and members of the House Ways and Means Committee. My name is Tom Wilkins and I am a resident of Reston, Virginia. I appear before you this morning to share my views on the economic impact of the high cost of prescription drugs.

Prescription drugs are not a luxury for me. They are a must and essential to me to stay alive. Admittedly, my quality of life is somewhat reduced due to my multiple chronic illnesses. I, like you and most people, wish to live a full and productive life—one that is free of undue emotional strain caused by an inability to purchase medications to treat my multiple illnesses.

I am a disabled veteran and a former combat soldier. I was left with permanent physical injuries and resultant psychological and emotional scars. I am also a cancer survivor. Unfortunately, the list goes on. I contracted a rare, serious illness that completely changed my lifestyle to the point that I was placed on a daily regimen of powerful and potent prescription medication. The medication had devastating secondary effects on my body by creating other chronic illnesses. More specifically, medication designed to treat my diagnosis of acute "polymyositis" which had gone undiagnosed for six months, led to my contracting lupus, another life-threatening illness. There is no known cure for either polymyositis or lupus. The cost of needed medication is almost prohibitive. Yet, I must take the medication to maintain some semblance of a quality of life, albeit a reduced quality of life.

Superimposed on those dreadful illnesses were the secondary effects of the medication prescribed for those illnesses. The medication prescribed induced the onset of diabetes, high blood pressure and other associated illnesses. I merely mention my personal experiences to illustrate the need for affordable medications, especially for those of us who suffer from multiple illnesses and who find it virtually impossible to purchase needed medications.

I find the cost of needed medications prohibitive even though I participate in the Medicare program and I also subscribe to a major health care plan. Even with both of these medical plans available to me, I find myself spending a high percentage of my disposable income to purchase prescription medication, just to stay alive. This ought not be the case.

Something should be done to address this critical national problem. I commend you for your efforts in addressing this troubling economic matter to millions of fellow American citizens.

Thank you

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